FERTILITY COUNSELLING IN FINNISH PRIMARY HEALTH CARE

Current practices in the family planning centres of Helsinki, Tampere, and Turku

Minna Kaattari
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University of Tampere
School of Health Sciences
(Public Health)
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University of Tampere
School of Health Sciences
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Supervisor: Dr. Pirjo Lindfors
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The trend to delaying childbearing in the developed countries seems evident, with the average age of first birth for mothers currently being around 30 years globally. In Finland, where the present study was conducted, the average age of first-time mothers was 28.5 years in 2013. Postponing childbearing is a complex social process influenced by several economic, social, and personal factors. Also, research indicates that a lack of accurate information may influence the decisions done on parenthood which in turn can have implications to adverse maternal, foetal and infant outcomes, and infertility.

There is a need to enhance awareness and increase fertility knowledge. In order to make this goal feasible, it is critical to examine the current practices related to fertility counselling (which aims to increase knowledge on fertility) provided in primary health care. The main aim of the present study was to examine the current practices of fertility counselling in the context of sexual health services provided in the family planning centres of three major cities, Helsinki, Tampere, and Turku. The study also aimed for producing information on the perceptions of the sexual health professionals on the importance and availability of fertility counselling within the public sexual health services.

This study seeks to answer to the following research problems: are the professionals familiar with the term and the concept of fertility counselling; do they see fertility counselling important for their work and for sexual health services; how work circumstances challenge and/or support and enable fertility counselling as a part of their work; and finally, are there gaps between the need of information on fertility and actual practices, especially in relation to fertility counselling given in the context of age and Chlamydia infection.

The qualitative data of the present study have been gathered through a survey executed as a questionnaire consisting of open-ended questions. The participants have been identified among the personnel (mainly nurses and physicians) working in the field of sexual health services or family planning in the family planning centres of Helsinki, Tampere, and Turku.

According to the findings, fertility counselling is acknowledged as an essential part of both contraceptive counselling and sexual health services and it is widely given within the other services provided in the family planning centres. However, it appears that some gaps between the need for counselling and actual practices still remains and it seems that whereas Chlamydia-related fertility counselling is a close to a norm within contraceptive counselling the need for the counselling related to the impact of ageing seems largely unmet. Thus, it is recommended that fertility counselling and especially age-related counselling should be targeted for everyone and at every level of health care services in order to achieve comprehensive level of fertility awareness. Sexual education given in all levels of educational health and the integration of fertility counselling as a part of services provided in the primary health care are crucial for meeting this goal.

The results of this study may be utilised in the future planning and integration of sexual health services and especially fertility counselling within sexual health care and primary health care as well as in planning for the training of the sexual health professionals.

Keywords: fertility counselling, ageing motherhood, delayed parenthood, sexual health services, views of the health professionals

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LIST OF ABBREVIATIONS AND ACRONYMS

CDC	Centre for Disease Control, USA
ICPD	International Conference on Population and Development
IPPF	International Planned Parenthood Federation
IUD	Intrauterine device
HIV	Human Immunodeficiency Virus
NHS	National Health Services, UK
PID	Pelvic inflammatory disease
SRHR	Sexual and reproductive health and rights
STI	Sexually transmitted infection
STM	Ministry of Social Affairs and Health
THL	National Institute for Health and Welfare
WHO	World Health Organisation

1 INTRODUCTION

The trend to delaying childbearing in the developed countries seems evident, with the average age of first birth for mothers currently being around 30 years globally (Daniluk and Koert 2015; National Vital Statistic Reports 2013; ESHRE 2005; Nicoletti and Tanturri 2005). In Finland, where the present study was conducted, the average age of first-time mothers was 28.5 years in 2013 and women aged 35 or more formed 11.5 per cent of them (Vuori and Gissler 2013). While postponing childbearing may be due to the specific economic and social realities today's women and men may have to deal with larger proportion of adverse maternal, foetal and infant outcomes, and infertility (Daniluk and Koert 2015).

The complexity of the process of making a decision to postpone parenthood involve many social, economic, and personal factors, such as the financial expenses of childrearing; the childcare options and their quality and cost; the economic consequences of career gaps; culture and its norms and habits; individual beliefs on raising children; individuals' views of their readiness for parenthood; relationship status; and partner suitability and readiness (Hammarberg and Clarke 2005; Abma and Martinez 2006; Proudfoot *et al.* 2009; Cooke *et al.* 2010; Mills *et al.* 2011). Moreover, research indicates that in addition to these circumstances a lack of accurate information may influence the decisions done on childbearing (see e.g. Virtala *et al.* 2011; Lampic *et al.* 2006).

There is a need to enhance awareness and increase fertility knowledge. In order to make this goal feasible, it is critical to examine the current practices related to fertility counselling (which aims to increase knowledge on fertility) provided in primary health care in the light of recent trends on parenthood and the recommendations of the *Sexual and Reproductive Health Action Programme 2014–2020*[1] of the Ministry of Social Affairs and Health. As Daniluk and Koert (2015) have stated, "While we cannot change the economic and social realities faced by the current generation of women and men, we can try to ensure they have ready access to accurate information about fertility […]".

1.1 The aim of the study

A need to examine current practices of fertility counselling provided in the sexual health services

[1] From this point on, an abbreviation Action Programme 2014–2020 or the Action Programme will be utilised for the Sexual and Reproductive Health Action Programme 2014–2020.

offered in Finnish primary health care appears evident. A lack of research on fertility counselling both in Finland as well as globally seems eminent. Internationally, cancer and infertility treatments have been the main focuses of the executed research. The few studies produced in Finland (see e.g. Brandt 2013) have mainly covered the views of students as a possible target group for fertility counselling.

However, no research has been executed in relations to the current practices and to the views of professionals working in the field. Especially the role fertility and fertility information play in the current sexual health services provided in primary health care should be studied and evaluated in the light of the recent fertility and other sexual health trends in the Finnish society.

These trends include namely the rising average age of primiparas[2] and postponing parenthood in general as well as the constant rates of *Chlamydia trachomatis* infections. The earlier positive declining trends have reversed since the mid-1990s and the rates of new infections vary around 13 000–14 000 new cases per year (Hulkko *et al.* 2010), causing possible adverse consequences for fertility of men and especially women. These trends and the way they change the need for fertility counselling should be studied in the light of the challenges it may cause for sexual health services.

The Action Programme 2014–2020 of the Ministry of Social Affairs and Health recommends that fertility counselling should be introduced as a part of basic health care services and contraceptive counselling. Fertility counselling is also urged to be included into the sexual education provided for the students of lower secondary school, vocational school, and senior secondary school. The counselling should contain information on age-related effects on fertility as well as those related to the STIs. One of the goals of these measures is to produce positive effects on reducing subfertility[3].

At this stage, it is uncertain at which level these recommendations are currently followed in the publicly funded health care and if fertility counselling is given to the clients of these services to any extend. Therefore, taking into account the recent developments, it is necessary to both study the current practices of fertility counselling and further explore possible measures to be taken into consideration when planning for the development of the related services. In this study the focus is on producing new information on the topic by concentrating on the family planning centres and the current fertility counselling practices in three major cities, Helsinki, Tampere, and Turku.

The main objective of the present study is to *examine the current practices in fertility counselling in*

[2] Primipara is a woman who is giving birth for the first time (Stevenson 2010)
[3] Reduced or impaired fertility (Ibid.)

the context of sexual health services provided in the Finnish primary health care. In order to answer the main question, it is also necessary to ask *whether the professionals familiar with the term and the concept of fertility counselling*; *whether they see fertility counselling important for their work and for sexual health services; how work circumstances challenge and/or support and enable fertility counselling as a part of their work;* and finally, *whether there are gaps between the need of information on fertility and actual practices,* and, related to this, *whether fertility counselling is given to the clients for example in the context of Chlamydia trachomatis infection* and *what is the situation with age-related fertility counselling*. The results produced may be utilised in the future planning and integration of sexual health services and especially fertility counselling within sexual health care and primary health care as well as in planning for the training of sexual health professionals.

1.2 Background

Since 1987, the average age of primiparas in Finland has risen for two years, being 28.5 years in 2013 (Vuori and Gissler 2014). During the same period, the average age of all women giving birth has changed from 28.9 years in 1987 to 30.4 in 2013. Also, the average age of becoming a father is on rise – in the beginning of the 1990s, the average age of first-time fathers was slightly over 28 years whereas presently it is closer to 31 years (Statistics Finland 2014a). In general, postponing parenthood has become common in Finland. Many educates themselves spending years in universities and after the graduation concentrate on building a career (Miettinen and Rotkirch 2008). Also, the nature of the relationship as well as the perceptions of the "maturity" for becoming a parent may be reasons to delay childbearing (Virtala *et al.* 2011). These findings are aligned with Maheshwari *et al.* (2008) view that delayed childbearing has become increasingly socially acceptable.

According to the *Action Programme 2014–2020*, prolonged studies create challenges for sexual and especially reproductive health counselling targeted for young adults. Different factors reducing fertility including *Chlamydia trachomatis* infection and several environmental and lifestyle factors such as tobacco smoking and obesity accumulate with age (Unkila-Kallio and Ranta 2012). As stated by Virtala *et al.* (2011), fertility awareness among university students in Finland is insufficient. More than half of the male students and about one-third of the female students falsely identified the marked decline in female fertility to begin after 45 years of age.

There are also misconceptions of the chances of bearing children at an older age among the

university students. Similar results have been collected for instance in Sweden (Lampic *et al.* 2006) and in the UK (Bunting and Boivin 2008). Hence, Virtala *et al.* (2011) have justifiably recommended that information on the age-related declines in fertility should be included in sexual health education and health promotion. This view is also supported in the *Action Programme 2014–2020* which calls for fertility counselling as well as counselling and care promoting reproductive health to be integrated as a part of health promotion through health services.

1.3 Material and resources

This study concentrates on sexual health services provided in primary health care and the professionals working in this field in the City of Helsinki, Tampere, and Turku. Helsinki has been chosen as an area of interest as the average age of mothers is the highest in the hospital district of Helsinki and almost quarter of parturients aged 35 and over give birth in the hospital district of Helsinki and Uusimaa. The hospital districts of Pirkanmaa and Varsinais-Suomi, where Tampere and Turku are the biggest cities, follow the lead of Helsinki. In Helsinki, as in the two other cities, sexual health services have been integrated a part of primary health care provided in health centres but the cities also offer specialised sexual health services in centralised family planning centres.

The qualitative data of the present study have been gathered through a survey executed as a questionnaire consisting of open-ended questions. Thus, the respondents of the study have been encouraged to comment the topic freely as well as bring forward their professional opinions on the topic. The participants have been identified among the personnel (mainly nurses and physicians) working in the field of sexual health services or family planning in the family planning centres of the respective cities.

The present study commences with the literature review discussing the concepts and definitions relevant for the topic; the context where fertility counselling is provided, the present status of certain aspects of Finnish sexual health and the way changes within these aspects and the previous research create grounds for this study. The first section of the literature review contains the conceptual landscape of the study, dealing with the concepts of fertility counselling and sexual health services as well as related concepts of sexual and reproductive health, sexual and reproductive rights, fertility and infertility, sexually transmitted infections and Chlamydia, and, finally, family planning services in primary health care. These notions are first defined and then briefly explained in the light of fertility counselling. This section is followed by a chapter on the

basis of sexual health services, covering the international agreements and Finnish legislation on providing sexual health services as well as the recent action programme for promoting sexual and reproductive health. Thus, it aims to present the context in which fertility counselling is given in Finland. The literature review concludes with a section that explores the present status of certain aspects of Finnish sexual health as well as provides a justification for the present study in the light of the previous research on fertility counselling and the changes in Finnish sexual health.

The literature review is followed by an introduction of the research aim and objectives of the study. The study design, sampling of the participants as well as the data collection and data analysis are discussed in the chapter six – the present data are qualitative one, conducted within the personnel of the three family planning centres and collected through a questionnaire with open-ended questions instead of a more traditional method of interviewing. In the present study, the analysis followed the model of Miles and Huberman (1994) with certain alterations which were mainly related to the practicalities of the analysis and are described in detail in the section 6.4.

The topics of methods and data analysis are succeeded with a presentation of the study results. This section introduces the main findings of the data under the five themes identified during the data analysis, *familiarity, importance, circumstances, meeting the needs,* and *availability*. The key points identified in the results are further elaborated in the final chapter of the study which also summarises the main findings and provides conclusions and recommendations for the development of fertility counselling. Along with the conclusions the strengths and weaknesses of the study as well as ethical consideration related to conducting the study are discussed in the final chapter. The chapter finishes with the suggestions for future research.

2 THE CONCEPTUAL LANDSCAPE OF THE STUDY

In the following chapter the main concepts of the study are defined and briefly discussed in the light of fertility counselling. The concept of fertility counselling together with sexual health services form the basis for the study. Fertility counselling is a vital element for maintaining and achieving good sexual and reproductive health through information and education. Sexual and reproductive rights, which are tightly connected to the concept of sexual and reproductive health, create a framework for providing fertility counselling. The relationship between fertility counselling and fertility and infertility is self-explanatory as the counselling aspires to maintaining fertility and reducing infertility in the population. Chlamydia as the most frequent sexually transmitted infection in Finland pose a possible threat to fertility and thus should be addressed in the counselling. Finally, family planning centres offer the actual settings for providing fertility counselling in primary health care.

2.1 Fertility counselling

Fertility counselling, together with contraceptive counselling, creates a basis for family planning and counselling in the Finnish health care system. The aim of the fertility counselling is to increase awareness of fertility related matters, such as how pregnancy starts, when pregnancy is possible, which factors have an effect on pregnancy, and which factors can reduce the possibility of it. Fertility counselling can provide a pre-emptive means for mitigating factors that reduce fertility, including ageing, Chlamydia infections, obesity, and smoking (Anttila 2002).

The definition of *sexual health services* and activities included within depends on the description of sexual health in use (Sannisto 2010). According to WHO (2006), the purpose of sexual health care is "the enhancement of life and personal relations, and not merely counselling and care related to reproduction and sexually transmitted diseases". The *Action Programme 2014–2020* (Klemetti and Raussi-Lehto 2014) lists the following services under sexual health services in Finnish health care organisation:

- Counselling and care targeted on promoting reproductive health
- Counselling and care during pregnancy
- Care during childbirth and puerperium[4]
- Contraceptive counselling
- Infertility testing and treatment

[4] The period of about six weeks after childbirth during which the mother's reproductive organs return to their original non-pregnant condition (Stevenson 2010).

- Counselling and referrals for termination of pregnancy
- Prevention, testing and care of sexually transmitted infections
- Sexual counselling and other sexual health promotion for different age groups
- Sexual counselling and therapy as well as clinical testing and care for sexual problems

The following subchapters 2.2–2.6 briefly discuss other concepts and definitions related to fertility counselling such as sexual and reproductive health, fertility and issues related to it, as well as STIs.

2.2 Sexual health and reproductive health

Fertility counselling should be seen as a vital part of sexual and reproductive health as it aims for maintaining both fertility and wellbeing of a person. In providing sexual health services it should be linked to measures that work for changing sexual behaviour through sexual and reproductive health knowledge as well as sexual education.

According to the World Health Organisation WHO (2006), the Programme of Action of the International Conference on Population and Development (ICPD) in 1994 was the first time *sexual health* was affiliated with reproductive health. Nevertheless, the term had already been defined in 1975 as "the integration of the somatic, emotional, intellectual and social aspects of sexual being in ways that are positively enriching and that enhance personality, communication and love" by a WHO expert group. Subsequently, the term was further developed and refined in 2002, reflecting the organisation's universal definition of health from 1946:

> [S]exual health is a state of physical, emotional, mental and social well-being in relation to sexuality; it is not merely the absence of disease, dysfunction or infirmity. Sexual health requires a positive and respectful approach to sexuality and sexual relationships, as well as the possibility of having pleasurable and safe sexual experiences, free of coercion, discrimination and violence. For sexual health to be attained and maintained, the sexual rights of all persons must be respected, protected and fulfilled. (WHO 2006)

Even though this 'working definition' (as categorised by WHO itself) does not represent an official position of WHO but serves as a contribution to the discussion, it has been instrumental in bringing the discussion of sexual health to the international public health forum (Edwards and Coleman 2004). Several other definitions (e.g. Lottes 2000) have rephrased and expanded the original definition suggested WHO. According to Edwards and Coleman (2004), the discussion of the concept and the definition of sexual health will continue to be influenced by historical events and political climates as it will remain highlighted in the international public health forum.

The development of the concept *reproductive health* was legitimised in the International Conference on Population and Development (Cairo 1994) and since then it has served as a more neutral umbrella for the notions of reproductive rights, sexual health, and sexual rights (Correa 1997). Nonetheless, most international actors, such as the European Union, have chosen to use the collective term of sexual and reproductive health. The ICPD Programme of Action (United Nations 1994) declares that "reproductive health [...] implies that people are able to have a satisfying and safe sex life and that they have the capacity to reproduce and the freedom to decide if, when and how often to do so".

The main elements of reproductive health such as information and an access to safe, effective, affordable, and acceptable methods of family planning are aiming for a safe pregnancy and childbirth, and having a healthy infant. Pregnancy and childbirth form the core of the concept. Termination of pregnancy as well as birth control, which are central to sexual health, are also included under the concept (Sannisto 2010). Thus, these concepts overlap. However, as Sannisto (2010) stated, rephrasing Lottes (2000) and Kosunen (2006), in general, the concept of sexual health is understood to include more than the health issues of fertile men and women. Hence, this paper also utilises the term sexual health.

Furthermore, the recent *Action Programme 2014–2020* draws the definition of sexual health from the original WHO one but the Action Programme further discusses the concepts of sexual health and reproductive health and the hierarchy between the two. In general, the concepts are understood as parallel and partly overlapping but most of all as an entity complementary to each other, sexual *and* reproductive health. According to the Action Programme, the comprehensive concept of sexual and reproductive health has been established in the Finnish national public health policy through the first action programme 2007–2011 and by founding of the sexual and reproductive health unit of the National Institute of Health and Welfare (Klemetti and Raussi-Lehto 2014).

2.3 Sexual and reproductive rights

The basic human rights of being free of coercion, violence and discrimination are critical to the realisation of sexual health. As Gruskin *et al.* (2007) stated, "Human rights provide an international legal framework within which the sexual and reproductive health needs and aspirations of all people can be considered." Both sexual health and reproductive health are closely connected to the question of sexual rights and at the international level these all are generally tied together, forming a

concept of sexual and reproductive health and rights (SRHR).

A working definition of *sexual rights* states "the fulfilment of sexual health is tied to the extent to which human rights are respected, protected and fulfilled". Also, it has been stated that "the application of existing human rights to sexuality and sexual health constitute sexual rights. Sexual rights protect all people's rights to fulfil and express their sexuality and enjoy sexual health, with due regard for the rights of others and within a framework of protection against discrimination". (WHO 2010; 2006.) These rights include for example the right to marry and to found a family and enter into marriage with the free and full consent of the intending spouses, and to equality in and at the dissolution of marriage as well as the right to decide the number and spacing of one's children.

While the ICPD in 1994 (nor its successor the Fourth World Conference on Women in Beijing in 1995 to that matter) did not specifically defined sexual rights it did elaborate on reproductive rights (WHO 2006). Later on in 2002 the WHO drafted a working definition of sexual rights together with a definition of sexual health (WHO 2006). Also, other international actors such as the International Planned Parenthood Federation (IPPF), and the World Association of Sexual Health (formerly World Association of Sexology) have their own definitions of sexual rights, emphasising sexual rights as a part of human rights recognised by the international community (Sannisto 2010).

While fertility counselling cannot be seen as sexual right *per se* it is tied to the right to information and education, especially when deciding on childbearing as well as to the general purpose of the rights, the protection of all people's entitlements to enjoy sexual health.

2.4 Fertility and infertility

The International Planned Parenthood Federation's (IPPF) definition of *fertility* describes to it as a reproductive performance which can either be understood at individual, group, or societal level (IPPF 2013). In societal or population level fertility is usually reported as a total fertility rate which is a measure relating the number of births in a given period to the number of women of reproductive age. The total fertility rate in Finland was 1.75 in 2013 (Statistics Finland 2014b).

Female fecundity[5] declines with advancing age (Perheentupa and Huhtaniemi 2009; The Committee on Gynecologic Practice of the American College of Obstetricians and Gynecologists and the

[5] The ability to produce an abundance of offspring or new growth; fertility (Stevenson 2010)

Practice Committee of the American Society for Reproductive Medicine 2008), and the reproductive phase in women is relatively short in comparison to their entire lifespan. In contrast, male fertility and reproduction suffer only a slight decline and are maintained until old age (Virtala et al. 2011). However, as the paternal age increases, the risk of miscarriage and, if the pregnancy is full-term, disease in offspring increase in parallel (Aitken & Krautz 2001; Aitken *et al*. 2004; Kleinhaus *et al*. 2006).

Fertility is usually something that is noticed only after experiencing problems with it. These problems can either relate to subfertility, if the inability to conceive is not absolute, or infertility. *Infertility* is often defined and usually understood as "the inability of couples of reproductive age, who are having sexual intercourse without contraception, to establish pregnancy within a specified period of time" (IPPF 2013).

The relationship between fertility counselling and fertility and infertility is self-explanatory; the concepts are essential for the counselling which aims at maintaining female and male fertility as well as reducing subfertility through guidance and education.

2.5 Sexually transmitted infections and Chlamydia

Sexually transmitted infections (STIs) are commonly defined as "infections that are spread primarily through person-to-person sexual contact" (WHO 2013). There are more than thirty known sexually transmitted bacteria, viruses, and parasites that cause gonorrhoea, chlamydial infection, syphilis, trichomoniasis, chancroid, genital herpes, genital warts, human immunodeficiency virus (HIV) infection, and hepatitis B infection. The most common STIs in Finland are chlamydia, gonorrhoea, and syphilis.

Chlamydia is a sexually transmitted infection caused by the bacterium *Chlamydia trachomatis*. Chlamydial infection can cause urethritis, cervicitis, proctitis, pharyngitis, or conjunctivitis and it can also manifest a sequela, such as pelvic inflammatory disease (PID) on women or epididymitis on men. Both of these conditions can lead to infertility. Most of the carriers are asymptomatic, making the infection difficult to diagnose. Once detected, the infection can be effectively treated with antibiotics. (THL 2014.)

Certain STIs, in particular Chlamydia, can reduce fertility and eventually lead to infertility. Hence, it is extremely important to provide information and guidance on the possible effects infections may

have on fertility. The influence sexually transmitted infection may have on fertility should be discussed especially once diagnosed with an infection but the matter should also be mentioned as a source of possible complication in a general level of counselling.

2.6 Family planning services in primary health care

The declaration of Alma-Ata in 1978 was the first international statement highlighting primary health care as a solution for the WHO's 'health for all' strategy (WHO 2014). Finland as a WHO member country is committed to the principles described in the declaration (Kauhanen *et al*. 1998). According to the declaration, primary health care includes all the health services and functions related to health promotion as well as preventive, curative, and rehabilitating health care according to the population's need.

The definitions of *primary health care* vary and their bases differ from one another. Mattila (2005) defines primary health care services as services that are reachable for everyone in the population and are a foundation for the health care system of the country. Sannisto (2010) further elaborates this definition and argues that it includes several perspectives to the matter. According to her, primary health care can be seen as a function of health care, such as disease prevention and treatment. In addition, primary health care can be understood as a level of this function - it is the first contact a patient has with the health care services. The third perspective on primary health care according to Sannisto (2010) is the strategic or philosophical one which is based on the social equity principle (Kauhanen *et al*. 1998).

According to the Cairo Agreement (United Nations 1994), sexual health services should be tied to primary health care. In Finland, publicly funded health centres provide important sexual health services for the population (Sannisto 2010). Family planning and sexual health services provided in primary health care are crucial for provision of fertility counselling as they provide a logical setting for guidance on fertility related matters.

3 THE BASIS FOR SEXUAL HEALTH SERVICES

The present study draws its empirical data from family planning centres in three of the biggest cities in Finland. In the bigger cities such as Helsinki, Tampere and Turku, centralised *family planning centres or clinics*[6] constitute a separate unit within the municipality's health centre and thus function as a part of primary health care providing specific sexual health services.

In Helsinki, sexual health services are provided as a part of other primary health services in the health centre containing of 26 health facilities. These health facilities are concentrated on providing basic sexual health services such as prescribing contraceptives. The centralised family planning centre was founded in 2007 to service the population, especially the youth, in specific sexual health matters such as abortion. The family planning centre is focused on specialised contraceptive customers such as the youth and people with special needs.

The customers of the family planning centre in Helsinki are youth under 16 years of age starting contraception and those aged 17 or under planning abortion. Also, a female 19 or under is referred to the centre if a termination of pregnancy is not her first. The centre also provides insertions of intrauterine devices, IUDs (copper or hormonal), if a customer has never given birth, if menstruation has not yet started after giving birth, or if the procedure was unsuccessful at the customer's local health facility. Likewise, if an IUD removal proves to be unsuccessful at the customer's own health facility, the removal is managed at the centre. Also, inserting and removing contraceptive implants are performed only at the centre. Furthermore, customers with an illness, a specific social condition, or previous challenges with contraceptives are referred to the centre, as are the customers with a physical or other disabilities. (Helsingin kaupungin terveyskeskus 2014.)

In the city of Tampere, contraception services are divided between two health facilities based on the age of the client. Customers under 22 years of age are tended to at the youth clinic and the family planning clinic provides services for women over 22. As in Helsinki, the family planning clinic of Tampere concentrates on the initiation of contraceptive use and the procedures related to IUD and contraceptive implants. Also, complications related to contraception such as those related to a chronic illness of the client are attended to at the centre. (Tampereen kaupunki 2014.) The data collection of this study was conducted in the family planning clinic providing services for women over 22 years of age.

[6] The official name of the facilities varies between the cities. In this study a term family planning clinic is utilised.

In Turku, the services of the family planning centre, or the contraception clinic as it is officially called, are mainly directed at customers under 25 years old. The clinic provides youth with advice on contraception as well as, for example, emergency contraceptives (EC) free of charge (usually EC is available over the counter in pharmacies in Finland and costs approximately 13–19 euros). Older customers can utilise the centre's services if they experience problems with contraception and have a referral from a physician, nurse, or social worker. Check-ups after a birth are also carried out at the clinic if an IUD or implant is chosen for contraception. In addition, abortion and sterilisation are performed at the clinic for clients of all age. (Turun kaupunki 2014.)

In the following chapters I explain how the provision of these services is based on international agreements, Finnish legislation, family policies, and how fertility counselling may be provided in these units and elsewhere.

3.1 International agreements

The International Conference on Population and Development (ICPD) organised by the United Nations in Cairo in 1994 is considered one of the most important milestones in the promotion of sexual and reproductive health and rights. According to Bergman (2004), the conference was the first time reproductive rights were recognised as being integral to universal human rights. In Cairo, the global perspective shifted from restricting population growth to promoting individual's sexual and reproductive health. The objectives of the action programme agreed on at the conference included family planning services, services related to prevention and treatment of sexually transmitted diseases as well as safe abortion were tied to accessible and affordable primary health care (United Nations 1994). The Fourth World Conference on Women in Beijing in 1997 enforced and amplified the decisions made in Cairo (Bergman 2004).

Ten years after the Cairo conference the World Health Organisation WHO enacted in its general assembly the first global reproductive health strategy (2004) in order to advance the principles of the Cairo agreement. The strategy highlights five globally important sexual and reproductive health services principles: improving antenatal, perinatal, postpartum, and new-born care; providing high-quality services for family planning, including infertility services; eliminating unsafe abortion; combating sexually transmitted infections including HIV, reproductive tract infections, cervical cancer, and other gynaecological morbidities; and promoting sexual health. This strategy was updated in 2010 shifting the focus towards political decision-making and advocacy as well as

monitoring and evaluation of the regional reproductive health.

In 2001 before the publication of the global strategy, the regional office of WHO Europe released a regional strategy (WHO 2001) for its 52 member countries. The European Union has also produced resolutions regarding sexual and reproductive health. In 2002 European Parliament formulated a comprehensive resolution, which is based on among others the United Nations' Universal Declaration of Human Rights, the Cairo agreement, and the resolutions produced in its follow-up conferences (European Parliament 2002). In addition, in 2004 the European Council (2004) approved a strategy for the promotion of sexual and reproductive health and rights (Resolution 1399). Later on, work promoting sexual health began within the European Commission. For instance, in the communication published by the Commission in 2009 to fight against HIV the policies for the European Union are aimed at improving "the access to prevention, treatment, care and support, to reach migrants from countries with a high prevalence of HIV, and to improve policies targeting the population most at risk" (European Commission 2009). Also, sexual and reproductive health issues have been acknowledged in the EU development policy: in 2006 the European Consensus on Development stated that achieving universal access to reproductive health by 2015 is one of the goals of the policy (European Parliament, Council and Commission 2006).

It seems that many of these international agreements and policy papers have been created during the times when the challenges for fertility mainly referred to overpopulation and thus, the aims of the agreements have usually been towards reduction of fertility. The ICPD Programme of Action (United Nations 1994) discuss in length about different aspects of sexual and reproductive health and how counselling and care related to reproduction and sexually transmitted diseases are a vital part of sexual health. Yet, the specifics of counselling are left unstated. This is also the case with the European parliament's resolution on sexual and reproductive health (2002), which covers mainly high-quality sexual health services but do not define them. In the WHO's global strategy (2004) these services are defined to include infertility services but do not mention counselling on fertility.

The WHO regional strategy on sexual and reproductive health (2001) talks about informing and educating people on the influence of aging on sexual health but is unclear what this includes. Since the topic is brought up under the section of aging people it may not refer to fertility at all. Nevertheless, the ICPD Programme of Action considers late motherhood together with young age as some sort of a risk to pregnancies and births that should be prevented, detected and managed through counselling and family planning information. The European Council's Resolution 1399

(2004) may come to closest in discussing fertility counselling: under the issues targeted at the national strategies it is stated that the strategies should "provide age- and gender-appropriate, comprehensive sexual and reproductive information and education" and "taking into account the changing sexual and reproductive health needs over a person's life cycle". Though, yet again, the details of the information and education as well as the needs are left undefined. Hence, it is appropriate to conclude that fertility counselling is rather unfamiliar topic for these documents.

3.2 Finnish legislation and family policy

The Constitution of Finland (731/1999), the Primary Health Care Act (66/1972), and the Act on the Status and Rights of Patients (785/1992) create a basis for curative care (sairaanhoito) services (Sannisto 2010). The 1972 Act also introduced family planning services as a new field of preventive health care in the communal level in order to provide an easy access to contraception (Kosunen 2000). Finnish legislation contains several acts that legislate the rights to sexual and reproductive health as well as to sexual and reproductive health services. The basis for the *Action Programme 2014–2020* (Klemetti and Raussi-Lehto 2014) has been the sexual and reproductive health rights of the entire population and the main aim is on the reduction of inequality. Finnish policy is aimed at promoting sexual rights and has lately focused on improving the rights of those dependent on treatment (among others people with chronic conditions and disabilities, elderly people, and people with mental health problems) as well as the rights of undocumented persons, gender and sexual minorities, and youth (Klemetti and Raussi-Lehto 2014).

According to Sannisto (2010), sexual and reproductive health services are best seen as a part of general health promotion, which is advanced at least on the strategic level. Also, in the Quality Recommendations for Health Promotion (STM 2006) sexual and reproductive health is covered in the separate chapter. Nevertheless, the most significant of the strategies is the Sexual and Reproductive Health Action Programme 2014–2020 which is focused on promoting sexual and reproductive health through increasing knowledge, developing services, and affirming sexual education (Klemetti and Raussi-Lehto 2014).

The basis for the Action Programme 2014–2020 was built on the first action programme (2007–2011) released by the Ministry of Social Affairs and Health in 2007. The present action programme is focused on customer orientation and equality. Equal, individual, and respectful treatment of the customer in sexual and reproductive health services is highlighted and the customers should be

encountered without any kind of discrimination.

The structure of the current action programme follows mostly the form of the previous plan since it functions as an update of the former. Sexual counselling, and sexual and reproductive services have been integrated as a part of each individual topic. The aims and actions for more than a dozen topics are covered, and each topic includes also recommendations for parties responsible for these goals. Nonetheless, as the social and health care reform is currently still under way, the recommendations as well as responsible parties will adapt to those structural and functional changes resulted in the reform. However, the message of the programme has already been delivered through newsletters (a 2-sided brochure) that are targeted at the professionals and decision makers. The current topics range from sexual rights and childbirth to sexual health promotion and pre-conception care and health, which discuss for example the need for fertility information (THL 2015).

The focus of the current programme is four-folded: 1) youth, 2) men's sexual and reproductive health, 3) multiculturalism, and 4) good labour and birth related care. However, the programme covers several topics ranging from antenatal and other pregnancy topics, and from birth control to sexually transmitted diseases, sexual education, infertility, and research. New topics in the current action programme are sexual behaviour linked to sexual and reproductive health knowledge, sexual education, multiculturalism, and disability. Especially the addition of the section of sexual and reproductive health knowledge is important for this study as the action programme defines that fertility counselling should be provided as a part of health education in schools as well as in vocational schools and high schools.

In Finland non-governmental organisations have traditionally been important actors in the field of sexual and reproductive health. The Family Federation of Finland (Väestöliitto) which is the Finnish member of the International Planned Parenthood Federation (IPPF) aims at promoting sexual and reproductive health, and in 2006 it published its own political agenda for sexual health (Väestöliitto 2006). The agenda illustrates the main challenges for sexual health and sexual health services and pursues solutions and improvements for them. The Federation lists challenges such as inequality, youth services and desultoriness and irregularity of sexual health services. Väestöliitto’s suggestions for solutions and improvements highlight the roles of education (targeted both on attitudes and sexual health), research, training, and resources, stressing the importance of national programme on promotion of sexual and reproductive health. (Ibid.)

In addition to the provision of sexual and reproductive health services, policies on families and the

support offered to families shape the landscape of childbearing in Finland. In accordance with the Nordic model, equal and universal benefits as well as comprehensive services for all are characteristic for Finnish family policy. The biggest changes in the family policy occurred during the 1960s and 1970s when women started combining family and work with the encouragement of society (Kelhä 2009). This improvement of mothers' employment, together with the sustenance of relatively high fertility rate, and the promotion of paternal use of family leaves form the basis for the long-term objectives of family policy (Närvi 2014).

The aim of the current family policy is to ensure a safe childhood and to provide material and psychological support for parents having and raising children (STM 2013). The important part in the execution of this goal is the support provided to families: financial support, services, and family leave. Child benefit (monthly allowance calculated per child) and day-care services are the most important forms of financial support especially in securing an adequate level of income for families. Other concrete means of support are maternity, paternity, and parental allowance, housing support (including the general housing allowance, state-guaranteed housing loans, and other interest subsidies as well as tax subsidies for housing loans), childcare allowance, and maternal, paternal, and parental leave. (STM 2013.) This comprehensive benefit and support system has led Lainiala (2014; 2010) to argue, citing the Eurostat statistics, that Finnish families are rather well off as the risk of poverty among families is one of the smallest in Europe.

Based on these findings, it could be argued that the supportive nature of Finnish family policy has had a positive impact on the fertility rate and childbearing. According to Harknett, Billari and Medalia (2014), this is particularly true in the case of second or higher order births, which are more responsive to policy and environmental changes than first births. This observation is supported by the findings from the early 1990s when the fertility rate has remained high despite an on-going recession. According to Björklund (2007) and Rønsen and Skrede (2008), this levelling effect was attributable to Finnish family policy. However, it seems that Finnish family policy and its positive impact does not encourage early parenthood. Younger women (aged of 20–24 and 25–29) were the first ones to postpone childbearing during the 1990s recession, choosing to wait for more stable employment opportunities or further educate themselves (Lainiala 2014). Furthermore, maternity allowances (earnings-related or basic) are not high enough to encourage to students to have children – the minimum maternity allowance (24.02 € per working day in 2015) is lower than the unemployment benefit (Lainiala 2010) and while the student financial aid is not considered as income when calculating the allowance, the allowance is deducted from the student's yearly exempt amount.

Simultaneously, Finns study longer and start their careers later than previous generations. In addition, early careers especially among the women are typically unstable and filled with temporary employment contracts (Närvi 2014). Insecurity has become a normal part of working life and it has its implications on parenthood. Both Sutela (2013) and Lainiala (2012) have argued that employment and employment history play a role in the decision to start a family. In a follow-up study executed by Väestöliitto in 2011 (Lainiala 2012) it was noted that those who had a more stable employment history or who were employed at the time of the first research (2008) were more likely to have had children by 2011 than those who were unemployed or who had previous unemployment periods in 2008. Furthermore, the temporal nature of employment is inclined to delay parenthood – especially if the fix-term contract is the one of the woman's (Närvi 2014; Sutela 2013).

3.3 Fertility counselling

According to the Action Programme 2014–2020 (Klemetti and Raussi-Lehto 2014), both international and Finnish research have been executed on the level of knowledge of young adults have on age-related effects on fertility and pregnancy. It seems that some information gaps exist – in particular, among Finnish university students, one-sixth of female students and a third of male did not know that getting pregnant at 35 years of age is more challenging than at 25 years old (Nipuli, Klemetti and Hemminki 2012). Similar results have also been collected in Sweden (Lampic et al. 2006). Hence, Virtala et al. (2011) have justifiably recommended that information about the age-related declines in fecundity should be included in sexual health education and health promotion. This view is also supported in the *Action Programme 2014–2020* (Klemetti and Raussi-Lehto 2014) which calls for fertility counselling as well as counselling and care promoting reproductive health to be integrated as a part of health promotion through health services.

The Action Programme includes a chapter on preconception care and health including several recommendations on fertility counselling. The term preconception care and health includes all preconception counselling and care aimed at maintaining fertility even in situations where pregnancy planning is not (yet) timely; there is no(t yet) a will to plan pregnancy; conception has failed despite the hopes to conceive; or a pregnancy has ended in miscarriage or termination. The aim of the preconception care is to maintain and promote sexual and reproductive health, and to support the couple's relationship.

As a part of this aim the programme recommends that fertility counselling should be introduced as a part of basic health care services and contraceptive counselling. Fertility counselling is also urged to be included into the sexual education provided for the students of lower secondary school, vocational school, and senior secondary school. The counselling should contain information on age-related effects on fertility as well as those related to the STIs. One of the goals of these measures is to produce positive effects on reducing subfertility.

However, despite these efforts, it is rather unclear at what extent these recommendations are currently followed in publicly funded health care and whether fertility counselling is given to customers to any extent. In particular, none of the family planning centres or clinics targeted in this study mention fertility counselling or topics related to it on their websites – though, the service descriptions in general tend to be vague and cover only the main services provided by the facilities. Thus, any conclusions about the availability of the services cannot be drawn based on the website descriptions.

4 SEXUAL HEALTH IN FINLAND

In order to understand the need of fertility counselling more comprehensively it is necessary to set the study in the context of certain aspects of Finnish sexual health and the changes it has experienced prior and especially after mid-1990s and during the 2000s. The chapter begins with the discussion of population changes and especially the age-related variations in births and continues to the latest developments in infertility. This is followed by a review of current situation of Chlamydia transmissions as well as an analysis on the possible reasons behind the changes in Finnish sexual health. The chapter concludes with the justification of the present study setting it in the context of the changes mentioned and the previous research.

4.1 Births – age-related and regional variations

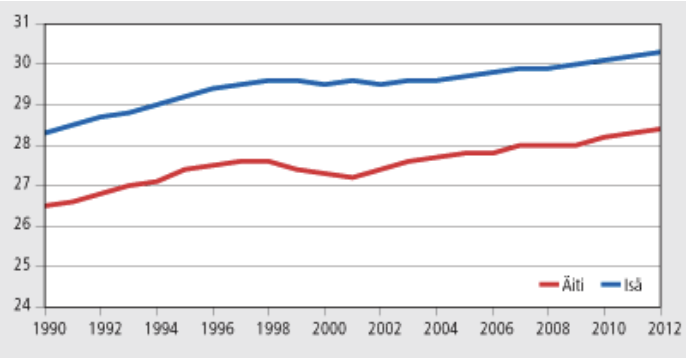
According to Statistics Finland's (2014b) data on population changes, the number of births in 2013 clearly decreased from the year before, resulting in a total of 58 134 births compared to 59 493 in 2012. The total fertility rate has slightly dropped, being 1.75 in 2013 (Statistics Finland 2014b). The mean age of primiparas has increased slightly, being 28.6 years in 2013 (ibid.). Of all parturients, for the first time 20 per cent were over the age of 35 (Vuori and Gissler 2014). During the 2000s, the mean age at first confinement[7] rose by one year. Also, there has been a slight change in the mean age of all women at confinement, currently 30.4 years. (Ibid.)

There are considerable regional variations in the distribution of the average age at first confinement. In 2013, the hospital district of Helsinki and Uusimaa (24.4%) had the highest proportion of parturients aged 35 and over, while the hospital district of Itä-Savo (15%) had the lowest proportion (Vuori and Gissler 2014). In addition, in the metropolitan area (mainly Helsinki and Espoo) the average age at first confinement was higher, around 30 years (30.5 in Helsinki in 2013), than in the rest of the country, which can be correlated to higher levels of education. Virtala et al. (2007; 2004) have shown that a university degree is the main reason for delaying childbearing. This is achieved mostly through the efficient use of contraceptives (ibid.).

In the hospital district of Helsinki the average age of primiparas was 30.5 years in 2013 (Vuori and Gissler 2014). When examining women with Finnish backgrounds exclusively, the average age is even higher. The proportion of women with immigrant roots is high in the metropolitan area and

[7] The condition of being in childbirth (Stevenson 2010)

they tend to have their children younger than women with Finnish background, mainly less than 30 years of age. However, the average age at first confinement varies between different ethnicities – average age within the primiparas with Somali background was 24.3 years whereas women with Russian or Thai background were closer to Finnish average, with 27.9 and 30.0 years respectively (Helminen 2013).



Source: Statistics Finland

Figure 1 The average age of first-time father and mother in 1990–2012

In general, postponing childbirth has become common in Finland. Many educate themselves spending years in universities and then building a career after graduation (Miettinen and Rotkirch 2008). Apart from women's average age, also the average age of becoming a father is on rise (Statistics Finland 2014a). At the beginning of the 1990s, the average age of first-time fathers was slightly over 28 years whereas currently it is closer to 31 years (Figure 1). These findings support Maheshwari *et al*. (2008) view that delayed childbearing has become increasingly socially acceptable.

4.2 Infertility

13–20 per cent of Finnish women and 9–11 per cent of men have reported experiencing infertility (in this case referring to the inability to establish pregnancy within 12 months of trying) (Klemetti 2004; Koponen *et al*. 2012). Absolute infertility or sterility, however, is rare and around 4 per cent experience it. It seems that infertility has become slightly more frequent since 2000 (Klemetti and Raussi-Lehto 2014). It is likely that the statistical differences between the sexes are mainly due to cultural reasons, for example the stigma of infertility among the men and the way men tend to perceive infertility; as a threat to masculinity (Gannon *et al*. 2004).

Sperm dysfunction, ovulation disorder, and fallopian tube damage are the most common reasons behind infertility (Cahill and Wardle 2002). These causes are affected by several factors such as age, being underweight and obesity, heavy smoking and alcohol abuse, certain medicines and anabolic steroids as well as reproductive tract infections, and occupational hazards (Klemetti and Raussi-Lehto 2014; Baird and Strassmann 2000). Fertility problems can affect either the woman (25 per cent of the cases) or the man (25 per cent) or the cause can be in both of them (25 per cent). However, it is not always possible to identify the cause and a fourth of infertility cases the cause is left unknown. (NHS 2014.)

According to Klemetti (2006) and Yli-Kuha (2012), there are socio-demographic differences in the prevalence of infertility as well as in seeking infertility treatments in Finland. Age and education are the most significant factors behind the variation of the prevalence of infertility (Yli-Kuha 2012). Women with higher education level might postpone childbearing to a later age when their fertility has already been affected whereas lifestyle choices affect the fertility of younger women with lower education level. Yli-Kuha (2012) argues that infertility treatment seeking appears to be more common in cities as well as among high educated and wealthy women despite the fact that infertility treatments are somewhat widely available both in public sector health facilities and private clinics (Klemetti and Raussi-Lehto 2014).

4.3 Chlamydia and other STIs

No significant changes in sexually transmitted infections (STIs) in Finland have been detected within the past five years (Jaakola *et al*. 2013). No changes were observed in the annual number of new cases; there has been no significant rise but then again no positive turn has been detected either. There are clear differences between the various STIs when it comes to the source of transmission and also the gender of the infected. Chlamydia being the prevalent cause of STIs in Finland is also most often acquired within Finnish borders. Likewise, it is the most feminised one: 59 per cent of the infected are women, causing a threat to their sexual health (Paavonen 2002) and possible complications such as infertility (Wikström 2013). Among the other common STIs (gonorrhoea and syphilis) as well as HIV the percentages of women vary between 26 and 35 per cent. Also, the majority of the STI transmissions have taken place abroad. (Klemetti and Raussi-Lehto 2014.)

Chlamydial infections take the main share of new cases annually and the majority of infections are diagnosed among people under 25 years old. The earlier positive trends of declining transmissions

have reversed since the mid-1990s. Since early 2000s the rates of new cases have varied between 13 000–14 000 new cases annually (Hulkko *et al*. 2010). In the year 2012 13 528 (249/100 000) cases of chlamydia were reported (Jaakola *et al*. 2013).

Despite the constant number of chlamydial infections the number of sequelae have declined since the 1990s (Wikström *et al.* 2012). According to Wikström et al. (2012) this trend is related to the occurrence of repeated Chlamydia infections. In their research a gradual increase of 43 per cent in repeated infections was detected in annual infections between 1996 and 2009. During a follow-up in 2009, it was noticed that a fourth of women and one fifth of men had ever had a previous Chlamydia infection. This rise is most probably due to sexual risk taking behaviour (especially among the adolescents) (Wikström *et al.* 2012).

Together with Chlamydia, gonorrhoea is an important preventable cause of pelvic inflammatory disease (PID) and infertility (CDC 2014). Recently it has become more common especially among young women, though the majority of diagnoses (74 per cent in 2013) are still identified among men (Klemetti and Raussi-Lehto 2014). In general, the bacterium is rather infrequent, and compared to the previous year, the annual number of cases showed a decrease, being 268 (4.9/100 000) in 2013. The means of transmission were identified in 81 per cent of the cases; one third of the infections were transmitted through sex between men.

Annual syphilis rates are rather low, 157 (2.9/100 000) new cases were detected in 2013, and only about a third of the diagnosed infections are observed among women (Klemetti and Raussi-Lehto 2014). The situation with HIV is similar: the annual rate of new cases is around 180, the prevalence rate of 0.1 is still on low European level (Liitsola *et al.* 2012) and 35 per cent of the new infections were detected among women in 2013 (Jaakola *et al.* 2013). According to Liitsola *et al.* (2012), the most prominent means of transmission in Finland is sex and currently heterosexual transmissions make up 40 per cent of the all diagnosed cases.

4.4 Factors behind negative changes in Finnish sexual health

Sannisto (2010) has argued that Finnish sexual health behaviour experienced a change for the worse in the mid-1990s, for example abortion numbers and teenage pregnancies increased, and more Chlamydia infections as well as sexually transmitted HIV infections were detected. In the literature several reasons for this development has been posed.

It has been suggested that today's Finns have gone through changes in their sexual behaviour compared to previous generations and are starting their sex life earlier than the generation in the 1980s (Sannisto 2010). They also have more sex partners, and they tend to use condoms and other contraceptives less frequently than their earlier counterparts. For instance, according to the FINSEX research, the average amount of sexual partners of women has quadrupled since 1971, being 10.4 in 2007, and the numbers of men's sexual partners has risen as well, from 11 to 14.7 partners (Kontula 2009).

Nikunen et al. (2005) have explained some of these changes are a consequence of the oversexualisation of Finnish society since the 1990s – sexual references in advertisement and media are just a tip of the iceberg of the phenomenon that may create falsified images of sex and sexuality as well as unrealistic expectations both in the youth and adult population (STM 2007). In addition, due to the recession there has been less sex education available at schools, and the recession and cuts had also an effect on the changes Finnish health care system went through during the 1990s. Also, some of the changes in Chlamydia rates were partly explained by changing over to sensitive diagnostic tests from 1995 to 2000 (Wikström *et al.* 2012).

Finnish sexual health has also experienced some recent changes. According to Heino, Gissler and Soimula (2014), abortions in the age group under 20 years old have systematically decreased since the 2000s. Among this age group the abortion rate was 10.5 per 1 000 women in 2013. This is the lowest since the Act on Induced Abortion took effect in 1970. Abortion rates among the youth which had started to escalate in mid-1990s were rolled back mostly due to some effective social changes: emergency contraception was made available prescription-free for everyone over 15 and sexual health education was added as a compulsory part of the school curriculum (Heino, Gissler and Soimula 2014).

Also, the total number of induced abortions in all age groups have either declined during the past 15 years or stayed stable. Women aged 25–29 are the age group with the steadiest rate, around 13 abortions per 1 000 women. However, the proportion of repeated abortions has increased and more than a third of women who had abortion in 2013 had had at least one previous abortion. (Heino, Gissler and Soimula 2014.)

This decreasing trend was also noticeable in pregnancies among 20 years old and younger. The

pregnancies among 15–19 years old were in a slight decline in 2013 compared to 2012, being 7.4 per 1,000 15–19 years old girl. When observing the development from 1987 to 2013, the trend of decline becomes very clear: during the late 1980s and early 1990s the pregnancy rate among age group 15–19 was as high as 12.4 (in 1988 and 1990, respectively) and slowly decreased being 9.0 in 1997. Another peak in the pregnancy rates was reached in 2002 with a rate of 11.2 but since then a steady decline has been witnessed. (Vuori and Gissler 2014.)

4.5 Fertility counselling – the need and previous studies

Maheshwari *et al.* (2008) argued that the emphasis put on avoiding teenage pregnancies has resulted in misconceptions in the community about age-related challenges for the conception and the results of infertility treatments. Simultaneously, a change in mean maternal (and paternal) age is being witnessed due to a change of lifestyle and career orientation – a concept of a kind of prolonged adolescence has been developed (van Balen 2005). Also, higher education as well as personal development and career building, the establishment of a more secure financial situation, and problems finding a suitable partner have been reported as social reasons for late parenthood (see e.g. Wilkie 1981; MacClennan Reece 1995).

These changes are true also in Finnish society as seen in the empirical evidence depicted in the sections 4.1–4.4. It seems that the changes in Finnish sexual health such as late parenthood may pose more challenges for maintaining good sexual health in future than for example teenage pregnancies. The average age of mothers is on rise, chlamydia rates has stayed unchanging, and age and education are the most significant factors behind the variation of the prevalence of infertility. Together with the prevention of STIs, which is also important for conserving fertility, information on aging and other factors influencing fertility should be available for people of all ages through health education and guidance provided in the primary health care. In order to make sense of the challenges these changes pose to sexual health fertility counselling should be introduced as a part of basic health care services and contraceptive counselling as well as health education, as recommended by the Action Programme 2014–2020.

Nevertheless, it seems that there is a lack of research on fertility counselling both in Finland as well as globally. Internationally, the research done has been focused on the research on cancer and infertility treatments. The few studies produced in Finland (see e.g. Brandt 2013) have mainly covered the views of students as a possible target audience of fertility counselling. However, no research has been executed in relations to the current practices or to the views of professionals

working in the field. In order to integrate fertility counselling as a part of sexual health services provided in primary health care it is essential to examine the practices already existing within the services in question. This is in every respect what this study is set out to do – to explore prevalent routines as a means to produce information that may help to execute the integration.

5 RESEARCH AIM AND OBJECTIVES

The aim of this study is to produce new information on the current practices of fertility counselling in the settings of sexual health services provided in the primary health care. The study takes place in the family planning centres of three major cities of Finland, Helsinki, Tampere, and Turku.

The main objective of the present study is to examine the current practices in fertility counselling in the family planning centres in order to produce beneficial information for the development of the practices.

In order to comprehend the type of information currently available in the Finnish health facilities the following research questions has also been discussed:

- Are the professionals familiar with the term and the concept of fertility counselling?
- Do they see fertility counselling important for their work and for sexual health services?
- How work circumstances challenge and/or support and enable fertility counselling as a part of their work?
- Are there gaps between the need of information on fertility and actual practices? Is fertility counselling given to the patient for example in the context of *Chlamydia trachomatis* infection? And what is the situation with age-related fertility counselling?

6 DATA AND RESEARCH METHODS

6.1 Study design

The study utilised a qualitative research method as a means to produce descriptive data on the views of the professionals working in the field of sexual health. According to Morse (2012), the qualitative health research and its methods are focused on gaining information on the individual's or group's perspectives, values, and beliefs. The focal point of qualitative research is on particular people or groups, who they are, and where are they located within a group (Given 2008) and it provides us with a sample of the language and culture under examination (Alasuutari 1999) Hence, as the target of the study was to highlight the perceptions of the sexual health professionals on fertility counselling the methods of the qualitative research were proven appropriate for the purpose.

A questionnaire with open-ended questions conducted through e-survey was used as a means of data collection. The purpose of the open-ended option was to produce qualitative and descriptive data through encouraging the respondents to comment the topic freely as well as bringing forward their professional opinions on the topic. Choosing a survey over a more traditional method of interviewing was also a practical decision – the participant units are located in three cities and interviewing would have required travelling to the locations as well as the transcription of the interviews which both are time-consuming. The basic assumption in making the decision was that this method would facilitate larger number of participants. Furthermore, it was interesting to experiment with a method that is still infrequently utilised in the qualitative research.

The method itself has been employed for instance by Puuronen (2012) in her study on promoting non-smoking among the youth. It enables a relatively rapid collection of qualitative data without a need for transcription of the data. The utilisation of the method is suitable particularly for qualitative research, which is not focused on the linguistic scrutiny but concentrates more on the contents. The benefits include also an easy access to the data (data was readily available online once the participants had responded) and the independence of the respondents (they can choose when and where to respond). In addition, for the participants the method of choice was less time-consuming than interviews would have been. One of the major challenges of the method has proven to be the response rate: since the method is often lacking personal contact with the participants, there is a risk of low response rate. Hence, the connection has to be built in other way and, for instance, using contact persons who then distribute information about the study among the participants is possible. In this case the researcher relies heavily on the contacts and the successfulness of the study depends

also on their activity and the way they inform the participants.

In the present study the contact persons were utilised to create a contact to the participants in all the health facilities participating the survey. These persons were either from the unit itself or someone in the administration such as chief administrative physician or chief nursing officer of the department. It seems that the position of the contact person within the participating unit was somewhat crucial for the activity of the participants and influenced positively the response rate of the participants whereas in those facilities where the contact person was located outside the actual unit the participation rate was lower.

6.2 Sampling

The sampling process commenced with the identification of the prospective cities for participation. According to the national statistics, the chosen cities Helsinki, Tampere, and Turku are the biggest cities of the hospital districts with the highest average age at first confinement and the highest proportion of parturient women aged 35 and over. The hospital district of Ahvenanmaa, which has the highest average age at first confinement after the hospital district of Helsinki and Uusimaa, was decided to rule out due to the small numbers of birth (280 births compared to the thousands of the chosen districts).

The prospective health care facilities (in this case family planning centres) in the chosen cities were approached through e-mail messages and phone calls in order to enquire the willingness to participate in the study and to identify potential participants. Purposive sampling method was used to follow Given's (2008) idea of sampling as something tied to the research objectives – as the main objective of the study was to look into the practices of fertility counselling in the primary health care, sexual health professionals working in the primary health care facilities were chosen as a target sample of the study.

The criteria used for the purposive sampling included (1) sexual health professional (a nurse, a doctor, or other professional in the chosen field); (2) being employed by the family planning centres (or other similar facilities) of the chosen cities; (3) willing to participate in the research through an e-survey. Further selection of the respondents was generally executed with a help of a chief administrative physician or similar of the health facility. Each sample varied according to the personnel of the chosen unit but consisted at the minimum of nurses and physicians.

In Helsinki, the chief physician of the unit was in charge of the identification of the participants and they included the entire personnel of the unit, being composed of four nurses, two part-time physicians and the chief physician herself. In Tampere, the chief administrative physician of the department of child and youth services helped with the identification process. These participants included three nurses and two part-time physicians. The chief nursing officer led the process in the unit in Turku, and nurses and physicians alike as well as sexual health professionals working in other units were identified. These participants consisted of three physicians, four nurses, and a midwife of the family planning centre and five public health nurses with expertise in sexual health from other units of the city.

6.3 Data collection

A questionnaire with open-ended questions (Annex 1) conducted through e-survey was used as a means of data collection and an invitation to the survey was sent to the respondents through e-mail. A web-based survey and data collection application (E-lomake, Eduix Oy, Finland, https://e-lomake.fi) was utilised as a technical aid. Together with the questionnaire the respondents also received a covering letter (Annex 2) that covered the main details of the research and ethical issues as well as included the contact information of the researcher. The survey was conducted anonymously but the participants were aware that there is a possibility that their responses are quoted in the study report. Responding the survey was interpreted as approving the procedure. In addition, the appropriate research permits were applied and received according to the regulations of each participating city (Annexes 3, 4, and 5).

The questionnaire form was structured so that it included altogether 15 questions about fertility counselling and it was slightly modified after the first response to include a background question of respondents' education. Other background information asked were the gender, age, organisation, work title and years in the current position. In the actual study questions the respondents were asked to utilise examples as well as otherwise encouraged to elaborate their answers further for instance using complementary questions. The first question covered the definition of fertility counselling and asked the respondents about their familiarity with the term. The questions 2–5 were related to fertility counselling as a part of their job, asking whether the respondent had given fertility advice to their clients, in which kind of cases the counselling was given, and how the customers had responded. The respondents were also enquired whether they had specifically given age- or

Chlamydia-related fertility counselling. The respondents who had not given fertility counselling were instructed to skip the questions 3–5 and move to the question number 6. The following two questions (6–7) dealt with the importance of the fertility counselling for the clients and also for the work of the professionals. The respondents were also asked whether they had discussed the topic with their colleagues, if they had received any training on the matter, and where they looked for or received further information on fertility counselling (questions 8–10). The challenges and benefits the work place and working environment provide for integrating the topic as a part of their work was also surveyed (questions 11–12) as were the importance of fertility counselling as a part of publicly provided sexual health services (questions 13–14). Lastly, the respondents were asked whether there were any aspects of the topic they would like highlight that had not been covered by the survey (question 15).

The data collection period varied between the units due to the administrative and schedule issues (the holiday period) and usually lasted 2–3 weeks, taking place between 15th of December 2014 and 21st of January 2015. After receiving the original invitation, reminders were sent from time to time for the participants not yet replied. In total, 15 out of 24 participants responded to the questionnaire, leading to a total response rate of 62.5 per cent. The activity of the participating organisation may have had an impact on the response rate of each unit – for example, in Helsinki the chief physician had discussed with all of the participants about the study in advance and the response rate was 100 per cent. The entire group of study respondents were women and they had worked in their current position between 3.5 and 39 years. The average age of the participants was 49 years, ranging from 27 to 63 years. While these background factors were not observed in the present research *per se* as there were not any significant differences between different age or occupational groups or between the organisations they are important for understanding the study population.

In Helsinki, six out of seven initial participants responded to the questionnaire – one of the nurses left her position in the middle of the data collection and thus was considered as dropping out of the study. Consequently, the total response rate was 100 per cent. All of the respondents were women, aged 45–58 years, and they worked as a physician (three) or a nurse (three). They had worked in their current position for 4–14 years.

In Tampere, out of the five identified participants, three of them (all nurses) responded on the questionnaire. The respondents were women, between 49 and 59 years of age and they had worked in their current position for 6–16 years. The two participants not responding were physicians. The total response rate was 60 per cent.

In Turku, in total 13 participants were recruited to the study and, unfortunately, only six of them responded. Thus, the total response rate was around 46 per cent. The respondents were all females and their ages varied between 27 and 63 years. They had worked in their current position between 3.5 and 39 years. Three of the respondents were nurses, two of them physicians and one worked as a midwife.

The final data was comprehensive and mainly broad, containing five pages of replies (Times New Roman 12, line spacing 1) from the 15 respondents. It seems that the participants were willing to discuss the topic as the responses contain generally more than one or two words. However, some questions engendered more discussion than others and the answers to the questions were also depended on the way the questions were formed. For instance, the questions with complementary questions – e.g. question 3: If you have [given fertility counselling], which kind of or in which context? How have the clients been taking it? – created longer responses including examples and further elaboration on the topic. However, this did not apply to all similar questions or to all respondents – sometimes the respondents replied with one word despite the complementary questions. The questions without any supporting questions mainly got short answers though some participants were more elaborative with them than others. The respondents were also consistent with their replies and only few questions were left unanswered by one or two respondents at the most (excluding the last question Is there any other aspect of the topic you would like to bring up that has not been asked about in the study?).

6.4 Data analysis

According to Tuomi and Sarajärvi (2009), in the data-driven qualitative analysis the intention is to create a theoretical structure based on the data as well as to describe the data verbally. Content analysis is text analysis, which identifies the meanings of the text by organising the data for the conclusions. The basic forms of the analysis, data units (such as words, sentences, phrases, statements, etc.), derive from the data and as such are not decided on beforehand. (Ibid.) In its most simplicity, the content analysis consists of three phases: *data reduction*, *data display* (usually through *clustering*), and *conclusion drawing* (Miles and Huberman 1994).

In this study, the analysis followed the data analysis model by Miles and Huberman (1994) with certain alterations, which are described below. The first step of Miles and Huberman's model is to

organise and reduce the data so that information irrelevant for the study is excluded. In this phase, information is condensed or divided into pieces and the process is being guided by the research questions. The idioms relevant to the research question are identified from the data and then listed. During this process, the data unit is also determined. (Polit and Hungler 1999; Burns and Grove 1997.)

The second phase of the model, data display, is based on clustering of the data. During clustering the original idioms or data units are carefully read through in order to identify concepts illustrating similarities and/or differences. The units describing identical concepts are assigned together under the same category or group and each group is named so that the content of the category is clear. (Hämäläinen 1987; Dey 1993; Cavanagh 1997.) Thus, the basis for the structure of the study and a preliminary description of the phenomenon under examination are created (Hämäläinen 1987; Dey 1993; Cavanagh 1997), and the stage for conclusions is set (Miles and Huberman 1994).

The last stage of the data analysis, conclusion drawing/verification, commences in fact as soon as in the beginning of the data collection as the qualitative analyst embarks on the meanings of the things under examination. However, these preliminary conclusions may not finalise until data collection is finished. The aim of the stage is to produce "valid, repeatable, and right" meanings for the data. The verification process, which is the second aspect of producing conclusions, offers means for "testing or confirming meanings, avoiding bias, and assuring the quality of conclusions". The process itself may be something as concise as browsing back to the notes or as extensive as a peer review or a replication of the findings in another data set. (Miles and Huberman 1994.)

In the present study, the process of data reduction was demonstrated through several practical steps. The process was initiated with outputting the data into an Excel workbook. The data were then rearranged so that each question had their own work sheet in order to examine the responses as a unity. Once the data were arranged it was necessary to read and re-read the responses in order to get familiar with the data.

Throughout this phase it began clear that the data were more straightforward than expected and the need for reduction was smaller than anticipated. Instead of concentrating on reducing the data at this point it seemed more logical to organise the fifteen survey questions according to each question supporting the research aim and examine the themes arising from the responses from this perspective. During this stage a fifth research question was added, as it seemed crucial to give voice to the professionals' views on the role of fertility counselling in the sexual health services provided

in the primary health care. Following that the central themes arising from the survey questions were brought together and arranged under each research questions through mind mapping. Throughout the processes of reducing the data and displaying the findings the consultation of the original data continued. Finally, the main findings were presented in the tables under five themes derived from the research questions.

In the analysis the findings were matched with five themes identified from and matched to the research questions. These five themes are presented in the tables, which show the progress of the analysis from the original statements to the categories and the final themes (Annex 6). This progress is demonstrated below using the table 1 as an example how the theme *Meeting the needs* was formed.

Table 1 The formation of the theme *Meeting the needs*

MEETING THE NEEDS			
Initial idioms and expressions	Categories	Results	Themes
- Age and its impact on fertility as an issue that should be reminded especially after the person has turned 30 - Given as a part of guidance for planning subsequent pregnancies - Sometimes, should be given more in general because the misbeliefs the youth have on the pills	Nearly everyone have given age-related FC (answered yes to the direct question) but in general the age-related matters of FC are very rarely mentioned - Age-related FC is understood as a part of the services but may not be fully implemented as a part of the practices/not a priority - Considering the easiness of bringing up the topics of FC, it should be relatively easy to discuss age as well	- The need for age-related FC seems unmet - Age-related FC should be further highlighted in the work of the professionals and also in training - The professionals may require more additional training/education on the matter	Meeting the needs
- Remarks like ‘always’, ‘of course’, ‘naturally’ - Hormonal contraception considered as a protective factor - Sometimes not mentioned if the first infection of the client (do not want to scare clients)	Everyone has given FC in the context of Chlamydia infections and there are several other references to it throughout the data	Giving FC in the context of Chlamydia infections seems like a norm and part of the routine -> The need of giving FC in the context of Chlamydia diagnoses seems to be largely met	

The results are presented so that the five themes identified during the data analysis, *familiarity,*

importance, *circumstances*, *meeting the needs*, and *availability*, are applied as the subheadings of the chapter. Within these five themes some statements of the respondents chosen from the data are presented to describe the data and support the results. These quotes have been written using italics.

7 RESULTS

7.1 The familiarity with fertility counselling

In the beginning of the survey the participants were asked about their familiarity with the term fertility counselling based on a description of the term that was given (below).

In this study, fertility counselling is referred as promoting knowledge on fertility. Fertility knowledge is knowledge of how pregnancy begins, when it is possible, which factors influence fertility, and which factors may reduce fertility. Fertility counselling may have a preventive effect on factors that may imperil fertility, such as underweight and overweight, smoking, age, and chlamydial infections. Fertility counselling aims for increasing fertility knowledge among youth and adults so they can make conscious decisions on fertility. (Brandt 2013)

Most of the respondents had heard the term in question before but it seems that it is not widely used within contraceptive counselling. The term itself was mainly familiar to the respondents from publications, training or discussions with colleagues. The topic is also widely discussed with the colleagues and they are important source of a knowledge-sharing. Despite the possible lack of familiarity with the term fertility counselling *per se*, the substance of the term and issues related to it are not only well-known but constitute an essential part of counselling given in the family planning centres. The respondents also felt that it is a critical part of their work description or education.

"Yes [I am familiar with the term]. [It] belongs to my basic education and work description." (Physician, 58 years)
"[I am familiar with the term] from all possible professional matters. It is an essential part of contraceptive practice and contraceptive counselling." (Nurse, 59 years)
"It is not possible to give counselling related to contraception without knowing this field." (Nurse, 59 years)

The familiarity with fertility counselling becomes particularly clear when examining practicalities related to it – all respondents have given fertility counselling as a part of their job in the family planning centres and it is considered as an essential part of sexual health services.

"Yes [I have given fertility counselling], it is a part of every client contact in some way, sometimes I talk about it more sometimes less, according to the need." (Nurse, 51 years)
"When you work in the contraceptive clinic, fertility counselling is given to every patient."

(Physician, 63 years)
"In my work in the contraceptive counselling I give fertility counselling to every client according to the individual need and situation […]." (Nurse, midwife, sexual counsellor and sexual therapist, 55 years)
"The foundation of all contraception is that it does not reduce fertility." (Nurse, 59 years)

Fertility counselling is considered as one of the most important topics of the counselling and it is given daily for the clients by some of the respondents. The contexts fertility counselling is given are relatively typical client situations within the family planning centres: prevention and testing of STIs; gynaecological appointments and cervical screening; terminations of pregnancy; removal or cessation of contraceptives due to pregnancy wishes; guidance on lifestyles and health behaviours; and guidance on and diagnosing of Chlamydia. The counselling especially in the context of Chlamydia diagnoses appears to be the norm – each respondent have not only given Chlamydia-related fertility counselling but there are several references to the counselling within Chlamydia cases throughout the data.

However, only few of the respondents mentioned age-related fertility counselling when asked to describe the client situations typical to fertility counselling. However, the professionals acknowledge the need and importance of it and they all claim to have given age-related counselling for their clients. In addition, references to the age-related fertility counselling are to some extent infrequent throughout the data and it does not appear to reflect to the need for it demonstrated in the previous research. Those few comments, nevertheless, allude to the clients' unfamiliarity of the issue and it seems clear that among the clients the need for additional age-related fertility counselling remains.

"Some women want to prolong the use of contraceptives and are not aware of reduction of fertility with age." (Physician, 48 years)
"Many are (still) surprised by how much getting pregnant is affected for example by woman's age." (Midwife, 44 years)

Also, it seems that among the professionals the need for training related to the topics of fertility counselling is somewhat unmet – a third of the respondents reported that they have received hardly any training or no training at all focused on the topic. Though, most of those who had not received any training on the topic have looked for the information elsewhere, for instance from articles and

publications such as those published by The Finnish Medical Society Duodecim and National Institute for Health and Welfare (THL) as well as from the Internet. In addition, the colleagues have proven to be a valuable resource in knowledge-sharing.

7.2 The importance of fertility counselling

When asked about the importance of fertility counselling for their work, all respondents considered it important, very important, or even inevitable. The respondents perceive fertility counselling important for several reasons. Quite a few of them recognise that fertility counselling plays an important role in their work as sexual health professionals working in the field of contraception.

"In my opinion, it [fertility counselling] belongs self-evidently to the job description of each midwife and nurse especially if working among contraception." (Nurse, midwife, sexual counsellor and sexual therapist, 55 years)
"Fertility counselling is important part of my main work and, in my opinion, very essential issue in a woman's life." (Nurse, 49 years)
"Yes, it is very important. Neglecting it (lack of knowledge) can have a big impact on the client's future." (Nurse, 51 years)

Also, the significance of the topic for the clients is largely acknowledged. In general, the fears and worries as well as the future of the clients seems to matter for the professionals and the aim of improving fertility knowledge among them is considered important reason for giving fertility counselling. Related to this is also the aim to reduce the impacts of risk factors such as age, weight, smoking, STIs (especially Chlamydia), and intoxicants. Also, some respondents highlight throughout the data the importance of giving fertility counselling to those clients who are planning a termination or have gone through a number of them.

Throughout the data the discussion on the target group of fertility counselling is rather gendered and it appears that female fertility is in the focus of this discussion – men or couples are rarely mentioned and their fertility do not seem to be affected by the counselling. The fertility is considered as vital for woman's life, and, hence, woman as whole should be taken into account at the practice in order to make the clients better understand their fertility and also have a better control over their childbearing. Undoubtedly this has something to do with the client profile of the contraceptive clinics but yet it should be acknowledged when planning for services.

The importance of fertility counselling is also demonstrated through the question of benefit. It is clear that, according to the majority's opinion, every client would benefit from fertility counselling. Particularly, it seems to be the clients with risky health behaviours, such as clients diagnosed with Chlamydia, who are overweight or smoking, who have had several sex partners, or planning for termination of pregnancy that are found to be the main targets of fertility counselling. Other specific client groups mentioned were those planning for pregnancy and younger girls or women who have not yet given birth.

"Everyone has a right to know about the issues affecting fertility." (Nurse, sexual counsellor, 51 years)
"In my opinion, everyone would benefit from counselling." (Nurse, 49 years)
"Everyone in the need of contraception (the youth and also older ones), clients afraid of the pills, those who are motivated in the health check-ups for weight control and smoking cessation, those considering termination, those in the STI counselling, in treating Chlamydia […]." (Nurse, 50 years)

Nevertheless, only one respondent mentioned the age of the client as a reason for clients to benefit from fertility counselling. Similarly, a single answer identified increased maternal age as a factor for the importance of fertility counselling while it seems clear, based on the rest of the questions, that age-related fertility knowledge is needed among the clients. Also, in this context the respondents are suggesting that the appropriate target group for age-related fertility counselling is women aged of 30 years or older.

"Many are (still) surprised by how much getting pregnant is affected for example by woman's age." (Midwife, 44 years)
"Some women want to prolong the use of contraceptives and are not aware of reduction of fertility with age." (Physician, 48 years)
"The impact of age on fertility is an issue that should be reminded of especially after age of 30." (Physician, 58 years)

7.3 The circumstances for giving fertility counselling

When asked about the possible challenges or obstacles their work poses it was felt by the most

respondents there are some factors that are challenging for giving fertility counselling. Lack of time, haste, or a short length of the appointment were identified as the most common barriers. Related to the time issues is also the matter of resources – a lack of staff and a good deal of clients to tend to.

"Constant haste, a great deal of clients, a lack of staff and short appointment times restrict and reduce the time for fertility counselling. Without these circumstances fertility counselling could be given more comprehensively." (Nurse, midwife, sexual counsellor and sexual therapist, 55 years)
"As a challenge lack of time at the practice […]. Not everyone make it to the practice fast enough." (Nurse, 49 years)

In addition, the accessibility of the services was questioned in the light of resources as it seems that not everyone have a possibility to have an appointment in time or when needed. Also, it appears that the structure of the services has been planned so that it is difficult to follow progress of the clients in the matters related to fertility counselling.

Nonetheless, not all respondents had experienced any obstacles in the context of their work, and, furthermore, all except one respondent (answer left blank) mentioned at least one benefit or enabling factor. Collaboration within and outside the unit and in general colleagues and discussions with them were mentioned as positive work circumstances. The job description and their education and training were also considered as supporting aspects. In addition, it was felt that as a field contraceptive counselling is enabling and supporting. The issues related to fertility counselling are relatively easy to advance with the clients since the situation itself already contains personal and intimate interaction.

"The topics discussed during the appointment are strongly related to fertility counselling and thus discussion and making questions feels natural." (Nurse, 27 years)
"[It is] a matter why people come to the practice. Easy to bring up into the discussion. A possibility to an individual and private interaction." (Nurse, 51 years)
"Work description is such that fertility counselling is already a part of the work. In the medical history it is asked about smoking, weight measured, height. It is easy to continue the discussion from there." (Nurse, 45 years)

Most of the respondents highlight the importance of clients and clients groups and their attitude towards fertility counselling as an enabling and supporting element. They felt that the clients are mainly receptive and interested about the topic as well as positive towards the issues related to it.

Sometimes the clients might even brought up the topic of fertility themselves, especially if they had problems related to the matter.

"The clients want it [fertility counselling], are aware and open for discussion." (Nurse, 59 years)
"In general the clients understand that these issues are a part of contraception appointment and respond positively." (Nurse, midwife, sexual counsellor and sexual therapist, 55 years)

Though, the clients are not always willing to receive the advice. This is the case especially if they have to improve for instance their health behaviour, and, due to some false presumptions, they may be worried for example about the impact of the contraceptive pills on fertility. At times the clients are also lacking information on the impacts of age has on fertility.

7.4 Meeting the needs: Chlamydia- and age-related fertility counselling

Every respondent has given fertility counselling in the case of Chlamydia infection and remarks like 'always', 'of course', and 'naturally' are common when asked about the Chlamydia-related counselling. There are also several other references to the counselling related to the Chlamydia cases throughout the data. Hence, it seems that giving fertility counselling in the context of Chlamydia infections is some sort of a norm and a part of the work routine for the professionals.

"In the context of acute Chlamydia it is important to explain the client how serious the infection is and what are the most serious implications of it." (Nurse, sexual counsellor, 39 years)
"Mainly in the client contacts related to the contraception often a protection from Chlamydia and a search for symptomless infections are brought up." [When asked about the context of giving fertility counselling] (Physician, 45 years)
"[At the practice] talking for example about how repeated Chlamydia infections may impede getting pregnant." (Midwife, 44 years)

However, there seems to be few exceptions to the norm, and sometimes the fertility effects of Chlamydia infections are not discussed at the appointment in order to not to scare the client. This was the case for example if the infection was the client's first. Still, it appears that Chlamydia-related fertility is given as a rule. Hence, the need of giving the counselling in the context of Chlamydia diagnoses can be seen as largely met within the services provided in the family planning centres.

In the case of age, nearly all respondents (one respondent was unsure) have given fertility counselling related to age within their work and the most common situations to address the issue are during the postnatal checks, contraceptive appointments, and family planning visits (e.g. when discussing about subsequent pregnancies).

"As a part of postnatal check it is occasionally discussed about the age and the fact that when wanting to have more children it is not advisable to postpone it too long." (Physician, 45 years)

Hence, age-related fertility counselling is understood as a part of the services provided in the family planning centres. Nevertheless, despite these examples, it may not be fully implemented as a part of the practices, or, based on the few references in the data, it is not considered as a priority. Thus, it is justified to argue that the need for age-related fertility counselling seems fairly unmet within the sexual health services in question.

In a similar manner, there are only few references to age-related fertility counselling throughout the data, and the topic is not brought up as often as other risk factors such as Chlamydia, smoking, or weight issues. Curiously enough, few of these remarks refer to the clients aged 30 years or older as a target group of age-related counselling but there are no similar indications to the younger clients in the same context. In general, based on the data, it seems that currently the youth are not considered as a main target group for fertility counselling.

However, one respondent felt that there should be more age-related fertility counselling available to the youth due to the prolonged use of hormonal contraceptives such as the contraceptive pills and the possible wrong impressions this might brought up.

"[It] feels that age-related fertility counselling should be generally given more since already quite a few youngster believe that using the contraceptive pills reduces the opportunity of pregnancy as childbearing as a rule has been postponed to >30 years of age and at that point the impacts of age may already be prominent."(Nurse, sexual counsellor, 51 years)

This poses a question of whether the object of the counselling should be reconsidered to cover the clients of every age, especially as the youth are the specific service users at the contraceptive clinics. In addition, the younger clients may have more opportunities to change their health behaviour due to the counselling than their older counterparts.

7.5 The availability of fertility counselling

All respondents consider fertility counselling as an important and essential part of publicly funded sexual health care and the significance is often expressed through remarks like ‘very important’, ‘extremely important’ or ‘indispensable’. Fertility counselling is considered one of the most important tasks of public health care and services related to it and goes together with sexual and contraceptive education. It is deemed to be significant for wellbeing and as such should be discussed at every appointment. When done so it is a long-term cost-effective option which enables possibilities for family planning.

“One of the most important tasks of the public health care.” (Nurse, 50 years)
“Very important and it should be further developed. Merely economically it would be more inexpensive for the society in the long run.” (Nurse, midwife, sexual counsellor and sexual therapist, 55 years)
“[Fertility counselling as a part of public sexual health services] is along with personal worries by and by cost-effective as many problems and possible treatments could be avoided in advance.” (Nurse, sexual counsellor, 51 years)

However, further development and reorganisation of the services are hoped for and scaling up the availability of the services seems needed. The respondents regard that fertility counselling should be a part of comprehensive sexual health services targeted for everyone. Hence, the services provided in primary and sexual health care should be scaled up starting from sexual education provided at schools in order to maintain the systematic provision of counselling and a good knowledge level on fertility issues. This, however, requires training and knowledge-sharing within the professionals and the facilities.

“Understanding the topic [fertility counselling] requires expertise so that the guidance and counselling of the client is explicit, trustworthy and effortless.” (Nurse, 50 years)
“In my opinion, more training on fertility counselling in particular for health care professionals should be organised by the society. Fertility counselling targeted on schoolchildren and students for instance at the health education lessons and us professionals should be utilised.” (Nurse, midwife, sexual counsellor and sexual therapist, 55 years)

Fertility counselling should be integrated into sexual education provided at the comprehensive

schools, upper secondary schools, and vocational colleges, and it should be given as a part of school and student health care at all education levels. Within the sexual health services the respondents felt that fertility counselling should be provided at contraceptive and maternity clinics as well as a part of other family-planning services and gynaecological check-ups. In addition to the sexual health services fertility counselling should also be organised within other services of primary health care. Those services include for instance basic services such as doctor's and nurse's appointments and health check-ups as well as services provided at the youth clinics.

"[Fertility counselling should be provided as a part of public sexual health services] along with chronic diseases/medications if they have an impact on fertility and a pregnancy wish is relevant." (Physician, 58 years)

"Also at the health centres or in the student health care there should be a few persons familiar with the topic [fertility counselling] who maintain the matter and share information with other personnel." (Nurse, 50 years)

8 DISCUSSION AND CONCLUSIONS

8.1 The general findings of the study

The main aim of the present study was to examine the current practices of fertility counselling in the context of sexual health services provided in the Finnish primary health care, mainly in the family planning centres of three major cities, Helsinki, Tampere, and Turku. The study also aimed for producing information on the perceptions of the sexual health professionals on the importance and availability of fertility counselling within the public sexual health services.

Fertility counselling is acknowledged as an essential part of both contraceptive counselling and sexual health services and it is widely given within the other services provided in the family planning centres. However, it seems that some gaps between the need for counselling and actual practices still remains. Especially when examining the two specific cases of the present study, age-related fertility counselling and fertility counselling in the case of Chlamydia infections, it becomes evident that whereas Chlamydia-related fertility counselling is a close to a norm within contraceptive counselling the need for the counselling related to the impact of ageing seems largely unmet.

The term of fertility counselling is recognised among the professionals but based on the findings it is not widely used within the family planning centres. These findings have some similarities with Brandt's (2013) outcomes on account of familiarity and usage of the term – among the university students the term was relatively unknown and it is not used in everyday life. However, the issues related to fertility counselling are not only well-known but constitute an essential part of counselling given in the family planning centres. It is also seen as a critical part of the work description or education of the professionals. The familiarity with fertility counselling is particularly evident when examining everyday practices at the centres –fertility counselling is routinely given together with contraceptive counselling and it is considered as an essential part of sexual health services. These findings support the views of the Action Programme 2014–2020 (Klemetti and Raussi-Lehto 2014) that the health professionals ought to give counselling to maintain and promote fertility as a part of services provided in the public health care as well as in the educational health care.

The educational health care and public health care in general are those fields of health care services

that are seen by the professionals as the main providers of fertility counselling. Also, the need for scaling up as well as further developing of the services are hoped for. These views fully correspond with the Action Programme 2014–2020 and its objectives. The Action Programme seeks to integrate fertility counselling as well as guidance and care promoting reproductive health as a part of health care services through health promotion when appropriate. Health promotion and promotion of healthy lifestyles together with the improvement of awareness of the association between fertility and age and STIs are also the means to reduce infertility according to the Action Programme. In general, based on the findings of the present study, fertility counselling should be targeted on everyone and at every level of health care services in order to achieve comprehensive level of fertility knowledge. This is especially important as it seems that fertility knowledge acquired at certain point of life may not be maintained later on without further education or another intervention (See Daniluk and Koert 2014 on fertility education online).

Sexual education given in the comprehensive education is crucial for establishing and maintaining the knowledge on fertility as it reaches the whole school age population. According to the Action Programme, it is important that sexual education given at schools includes counselling on fertility and the maintenance of it along with contraceptive counselling. Pre-conception care and health should also be enhanced in the student health care. The findings of the present study are in line with this view but suggest also youth clinics as one of the facilities providing fertility counselling as a part of their services. The Action Programme similarly acknowledges the need for more comprehensive knowledge on fertility among the youth (aged 20–24 years) in general as well as those young women and men who would like to promote their sexual and reproductive health but are not (yet) planning for pregnancy. In order to reach this part of the population, municipalities should offer guidance through low-threshold services within the primary health care. In the data this goal emerges through a wish for integration as a part of basic health services.

Low-threshold and related services are vital for promoting sexual and reproduction health among men. As stated by the Action Programme, this field of health has traditionally been connected with women and contraceptive and maternity clinics has been seen as targeted mainly for women. Thus, it has not been easy for men to seek guidance and care on sexual and reproductive health. This is visible also throughout the results, which highlight women as a main client group of the services as well as place their fertility in risk if fertility counselling is not provided. These views are supported by the observations of Brandt's (2013) study. In her study, male university students felt that women have more opportunities to obtain fertility information for instance through sexual health services.

In addition, men seem to think fertility issues less than women and, furthermore, most of the male students appear to receive fertility knowledge mainly from women in their lives instead of health professionals. Previous research (Virtala *et al.* 2010; Lampic *et al.* 2006) promotes this view of men as a group with less knowledge on fertility issues. Hence, following the Action Programme's objectives, family planning services including contraceptive counselling should be further develop in order to provide more comprehensive services also for men. With the intention of promoting both better sexual health and improved fertility knowledge among men they could in addition of having their own services be for example involved in their partners' contraceptive appointments.

While male fertility is not truly targeted at the services it seems that the youth and younger women are missing out especially when examining the current practices of age-related fertility counselling. Fertility guidance on age-related matters appears to be reserved mainly for those aged 30 years or older or those planning for their subsequent pregnancies. This calls for reconsidering the object of the counselling to cover the clients of every age, especially as the youth are specific service users at the family planning centres. In addition, the younger clients may have more opportunities to change their health behaviour due to the counselling than their older counterparts.

Moreover, in general level, the need for age-related fertility counselling appears to be undeniably unmet within the services provided in the family planning centres and it should be further highlighted in the work of the professionals as well as in training and education. The issue of training should also be considered both in educational health care and public health care when planning the scaling up of the services. However, this need has not been acknowledged in the Action Programme though it recommends that the counselling related to age and fertility is further stressed within the family planning and contraceptive services. With appropriate encouragement and training the topic should be easily further integrated into the services given that circumstances for giving the counselling for example clients' attitude are largely supportive.

When observing fertility counselling in the case of Chlamydia infection it come across as a norm within the services in question and fertility information is routinely given to those infected. Therefore, the need for Chlamydia-related fertility counselling in the family planning centres is largely met with a minor exception of the clients with the first Chlamydia infection who also should receive fertility information in the context of their condition. Along with this exception also the impact of termination of pregnancy on fertility ought to be addressed through training of the

experts. While induced abortion, which is the most prominent way of termination in Finland (Heino, Gissler and Soimula 2013), has no scientifically proved detrimental effect on fertility (Bord *et al.* 2014), several references on the association between termination (especially repeated ones) and fertility tell of the importance of the topic for the experts. This approach may be due to the possibility that the professionals feel that the pregnancy may be the client's sole chance to have a child. Yet, especially in the case of repeated terminations, it is useful to discuss the possible birth outcomes such as pre-term birth and the risk of low birth weight in the first birth after the terminations (Klemetti *et al.* 2012) as a part of contraceptive and fertility counselling. However, it should be acknowledged that with an exemption of the low risk of short-term complications there is little evidence on the association between induced abortion and secondary fertility (Bord *et al.* 2014; Lowit *et al.* 2010). Hence, the topic of abortion in relation to fertility counselling should be approached with care as it may be a delicate topic for the clients.

The attitude of the clients of the contraceptive counselling is mainly described as positive and they are receptive and interested in the issues covered in fertility counselling, sometimes as much as asking questions and being active on the matter. However, the active ones must have obtained some preliminary information in order to be able to address the issue on their own. Hence, there is a risk that those clients without the preliminary information will not receive guidance as they do not have means to ask for it. All things considered, it is clear that the clients of family planning centres lack fertility related awareness and information similarly to the students of Brandt's (2013) and Virtala *et al.* (2010) research. This need for fertility information could be met through extensive promotion of fertility counselling.

Preventive health care is equally beneficial to the public health and the individual, and counselling is important element of it. Though, promoting reproductive and particularly fertility counselling may not challenge the social realities or the structures of the society that make individuals to postpone parenthood. However, broad fertility knowledge and awareness achieved through comprehensive and versatile fertility counselling can give the future generations means to make conscious decisions on their fertility and childbearing.

Based on the present study the following conclusions are presented:

- Fertility counselling as a part of contraceptive counselling and other sexual and reproductive health services should be further integrated and developed in order to promote better sexual

health and improved fertility knowledge among both women and men.

- Especially critical is the need to make counselling focused on age and fertility available for both men and women and in all age groups. In addition, while the need for Chlamydia-related fertility counselling seems to be largely met within the services in question some measures could be in place to ascertain that each client will receive appropriate information in the light of the current infection rates.
- Fertility counselling should be targeted for everyone and at every level of health care services in order to achieve comprehensive level of fertility awareness. Sexual education given in all levels of educational health and the integration of fertility counselling as a part of services provided in the primary health care are crucial for meeting this goal. The youth should be in the core of this development as they may have more opportunities to change their health behaviour due to the counselling than their older counterparts.
- The results produced from the present study may provide valuable information for the future planning of fertility counselling as well as other family planning and sexual health services within the primary health care.

8.2 Strengths and weaknesses of the study

One of the main advantages of the present study is the contribution of new information in the field of family planning services and fertility counselling. As mentioned before, a very few preceding studies has produced research on fertility counselling and the practices and the perceptions of the professionals providing the counselling have not been focused on in the previous studies. The present study does not merely give a voice to the experts of the field but also provides useful information on how fertility counselling and its related issues are addressed and managed in the family planning centres. Furthermore, as the Action Programme 2014–2020 aims for further implementing fertility counselling as a part of sexual counselling as well as sexual education the present study offers some means on how to proceed with the implementation. Also, other strengths of the study include the fact that the study results are in line with the previous study (mainly Brandt 2013) and the objectives and goals of the Action Programme 2014–2020.

The researcher took a conscious risk in choosing open-ended questionnaire as a data collection method as opposite to interviews, the more traditional data collection method of qualitative research. Choosing a survey over a more traditional method of interviewing was fairly practical of a

decision – the travelling and the procedures related to the interviews would have been time-consuming and it was assumed that the chosen method would facilitate larger number of participants than interviews would have. In addition, for the participants the method of choice was less time-consuming than interviews would have been and more convenient as they were able to choose the time and place for responding. The researcher was interested in discovering the data the chosen method would produce considering that, as a method questionnaire is still closely associated with quantitative research and infrequently utilised in producing qualitative data.

Along with the benefits (as discussed in more detail in the section 6.1) the approach also proved to be challenging in the terms of responses: the connection to the participants had to be built through contact persons and the success of the response rate depended also on their activity as well as on their position within the organisation. The contact person within the participating unit was more successful in committing personnel to participate and influenced positively the response rate of the participants. In those facilities where the contact person was located outside the actual unit the participation rate proved to be lower. In addition to the lower than anticipated response rates it is possible that interviews may have provided alternative and perhaps more in-depth information on the topic. However, the method chosen succeeded in producing a form of saturation in terms of significant themes and perceptions and the data was comprehensive enough to produce relevant answers for the research questions. Hence, it can be concluded that, despite the weaknesses, the method choice was successful.

8.3 Ethical considerations

The participants contributed to the study voluntarily and responding the survey was interpreted as approving the terms of participation. The terms were explained to the participants in the covering letter and they were aware of a possibility to decline or discontinue their participation at any time if wished so. The starting point and the meaning of the study were also described in the covering note and the participants were provided means to contact the researcher if needed.

The participation did not pose any harm or risk for the participants and during the study no such situation occurred. The participants were aware of the topic under examination and responded positively on it. The data produced through the survey was handled confidentially and it was exclusively used in the present study. However, the results of the study are freely available for future studies. The anonymity of the participants was guaranteed as the respondents were only

identified through id numbers in the data output. Thus, not even the researcher knew the identity of the respondents and the names or the identities of the respondents were not compromised at any point.

The results of the present study are provided for the participating organisations and freely available for their disposal. The results produce beneficial information for the organisations on their current practices and may be used in further developing the practices related to fertility counselling. In addition, the present study may have improved the participants' awareness of the importance of the issue and thus may have resulted in enhanced counselling within the family planning centres.

8.4 Future research

As fertility counselling and related issues such as fertility awareness currently still require further research a comprehensive study would be in order. As argued already by Brandt (2013), defining the term of fertility counselling as well as establishing the use of the term are needed. In the light of the present study the two logical approaches to follow the study could include an intervention or an extension of the research to the other health facilities such as health centres and the counselling given there. The intervention could focus on providing enhanced fertility information within the contraceptive counselling given in the family planning centres and observing for instance the changes in the level of fertility knowledge of the clients. Another possible focal point for an intervention could be developed around the training need of the professionals. While the fertility awareness of the university students has been in many respects mapped by Brandt and Virtala *et al.* examining the fertility awareness of the clients of the family planning centres could also be in order considering the possible differences in the demographics.

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Annex 1 Questionnaire

QUESTIONNAIRE

Age:
Gender:
Title, organisation, education:
Years in the current position:

> In this study, fertility counselling is referred as promoting knowledge on fertility. Fertility knowledge is knowledge of how pregnancy begins, when it is possible, which factors influence fertility, and which factors may reduce fertility. Fertility counselling may have a preventive effect on factors that may imperil fertility, such as underweight and overweight, smoking, age, and chlamydial infections. Fertility counselling aims for increasing fertility knowledge among youth and adults so they can make conscious decisions on fertility.

1. The term of fertility counselling is described above. Are you familiar with the term? From which context?
2. Have you given fertility counselling as a part of your job? (If not, move to the question 6)
3. If you have, which kind or in which context? How have the clients been taking it?
4. Have you given age-related fertility counselling?
5. How about in the context of chlamydial infections?
6. Do you think that fertility counselling is important for your work? Why/why not?
7. Do you think that your clients would benefit from fertility counselling? If so, can you think of any specific client group/groups?
8. Have you discussed about fertility counselling at your unit or with your colleagues? Give an example.
9. Have you received any training related to the topic? Where and which kind of?
10. Where do you get or look for information related to fertility counselling?
11. In your work are there any challenges or barriers for integration of fertility counselling? What are these challenges/barriers and which way do you think they restrict giving of fertility counselling?
12. Do you think there are factors in your work that support or enable fertility counselling? Give an example.
13. In your opinion, how important it is to offer fertility counselling as a part of public sexual health services? Why/why not?
14. If you think that fertility counselling is important in which situation of situations or as a part of which services it would be offered as a part of public sexual health services?
15. Is there any other aspect of the topic you would like to bring up that has not been asked about in the study?

Annex 2: An announcement for the study participants

The aim of my MA thesis is to look into practices related to fertility counselling provided in the primary health care as well as the perceptions the professionals working in the field of sexual health have of fertility counselling. The topic has been formed together with the sexual and reproductive health unit of the National Institute for Health and Welfare, THL (supervisor MD Teija Kulmala). The thesis is a part of the English taught degree of Master in Health Sciences in the University of Tampere. For the reporting purposes the questionnaire form will be translated in English. The original Finnish questionnaire form will be attached as an annex of the thesis. The data collection will take place in Helsinki, Tampere, and Turku.

Data collection will be executed through e-questionnaire that contains open-ended questions. The responding takes about 20 minutes. The results of the study will be reported in the thesis anonymously. When necessary, the responses may be used in the report as citations translated in English and the researcher ascertains that the identity of the respondent cannot be identified from the citation used. Your identity, responses, and all the matters arising during the study are confidential and will not be given to outsiders. The participation is voluntary and the participants can drop out of the study at any point. It would be extremely desirable that you would answer as broadly as possible and illustrating with examples by latest on 31 December 2014.

As topic fertility counselling has been brought up in the new sexual and reproductive health promotion programme of the Ministry for Social Affairs and Health but it is still lacking research. The perceptions of the users of the sexual health services have been mainly the target of the previous studies but there is no earlier research on the views of the professionals. Hence, it is highly important that all the participants would response the survey as broadly and comprehensively as possible. The units participating in the study will have an access to the results, which will hopefully be presented also in the wider context among the sexual health professionals.

If you have any questions or you would like to discuss more about the study, please contact me.

Thank you for participating in the study!

Kind regards,
Minna Kaattari
040 540 6745, minna.kaattari@gmail.com
Terveystieteiden yksikkö, Tampereen yliopisto

Helsingin kaupunki **Pöytäkirjanote** 14/2014 1 (2)
Sosiaali- ja terveysvirasto
Terveys- ja päihdepalvelut
Terveysasemat ja sisätautien poliklinikka 2.12.2014
Terveysasemien johtajalääkäri

Minna Kaattari
Eerikinkatu 9 A 18
00100 Helsinki

16 §
Päätös tutkimuslupahakemuksesta HEL2014-013848

HEL 2014-013848 T 13 02 01

Päätös

Terveysasemien johtajalääkäri päätti myöntää tutkimusluvan Minna Kaattarin tutkimukselle "Fertility counselling in Finnish primary health care", tässä päätöksessä ilmenevin ehdoin todeten, että keskitetyn ehkäisyneuvonnan vastuulääkäri Satu Suhonen antoi hakemuksesta puoltavan lausunnon 18.11.2014. Terveysasemien johtajalääkäri nimeää yhteyshenkilöksi Satu Suhosen.

- Sosiaali- ja terveysviraston yhteyshenkilö on keskitetyn ehkäisyneuvonnan vastuulääkäri Satu Suhonen. Yhteyshenkilön tehtävänä on valvoa, että tutkimus toteutetaan sosiaali- ja terveysvirastossa suunnitelman ja lupaehtojen mukaisesti

- Tutkimuksesta ei saa aiheutua kustannuksia sosiaali- ja terveysvirastolle.

- Tutkimuksessa mahdollisesti syntyvä henkilörekisteri hävitetään tai arkistoidaan henkilötietolaissa edellytetyllä tavalla

- Tutkimusraportista ei ole yksilöitävissä tutkimukseen osallistunutta henkilöä

- Tutkija saapuu pyydettäessä maksutta esittelemään tutkimuksen tuloksia siihen yksikköön, jota tutkimus koskee

- Tutkimuksen valmistuttua tutkimusraportti tai sähköinen osoite, josta se on luettavissa, toimitetaan sosiaali- ja terveysviraston käyttöön (osoite Helsingin kaupunki, Kirjaamo, Sosiaali- ja terveysvirasto, PL 10, 00099 Helsingin kaupunki)

Lisätiedot

Irmeli Suvanto, kehittämissuunnittelija, puhelin: 310 42681
irmeli.suvanto(a)hel.fi

Otteet

Ote	**Otteen liitteet**
Hakija	Oikaisuvaatimusohje, sosiaali- ja terveyslautakunta
Yhteyshenkilö	Liite 1
	Liite 2
	Liite 3
	Liite 4
Toimistopäällikkö	Liite 1
	Liite 2
	Liite 3
	Liite 4
Valmistelija	

Pöytäkirja on pidetty yleisesti nähtävänä Helsingin kaupungin kirjaamossa (Pohjoisesplanadi 11-13) 5.12.2014 ja asianosaista koskeva päätös on lähetetty 8.12.2014.

Risto Mäkinen
vs. terveysasemien
johtajalääkäri

TAMPEREEN KAUPUNKI
HYVINVOINTIPALVELUT

TUTKIMUSLUPAHAKEMUS
Avopalvelut

Hakemuksen saapumispvm _____

1 TUTKIMUSLUVAN HAKIJA(T)

Sukunimi	Etunimi	Syntymäaika
Kaattari	Minna Tuulikki	071181
Osoite		
Eerikinkatu 9 A 18		
Puhelin	**Sähköpostiosoite**	
040 540 6745	minna.kaattari@gmail.com	

Sukunimi	Etunimi	Syntymäaika
Osoite		
Puhelin	**Sähköpostiosoite**	

Muut tutkimuksen tekemiseen osallistuvat henkilöt

Sukunimi	Etunimi	Syntymäaika
Osoite		
Puhelin	**Sähköpostiosoite**	

Tutkimuslaitos, oppilaitos
Tampereen yliopisto
Koulutusohjelma
Master in Health Sciences (Public health)

2 TUTKIMUKSEN OHJAAJA(T)

Sukunimi	Etunimi
Lindfors	Pirjo
Toimipaikka ja osoite	
Tampereen yliopisto, 33014 Tampereen yliopisto	
Puhelin	**Sähköpostiosoite**
040 190 1688	pirjo.lindfors@uta.fi
Oppiarvo ja ammatti	
YTT, Yliopiston lehtori (Terveystieteet)	
Sitoudun ohjaamaan tutkimusta **Päiväys**	**Allekirjoitus**
24.11.2014	Pirjo

3 TUTKIMUKSEN LYHYT KUVAUS (nimi, keskeiset tavoitteet, tutkimusmenetelmät, kohderyhmä)

FERTILITY COUNSELLING IN FINNISH PRIMARY HEALTH CARE

Tutkimuksen aiheen on hedelmällisyysneuvonta suomalaisessa perusterveydenhuollossa. Hedelmällisyysneuvonnalla tarkoitetaan hedelmällisyystietoisuuden (eli tietous hedelmällisyyteen ja raskauteen vaikuttavista asioista ja tekijöistä) lisäämistä. Tutkimuksessa tarkastellaan hedelmällisyysneuvonnan konseptia niin synnytyskeski-iän nousun kuin klamydiatartuntojen valossa sekä pyritään kartoittamaan hedelmällisyysneuvonnan nykykäytäntöjä perusterveyden huollossa ja ammattilaisten näkemyksiä asiaan.

Aineistoa kerätään Tampereella ja Helsingissä (sekä lisäksi mahdollisesti Turussa, Espoossa tai Vantaalla) ehkäisyneuvonnassa toimivien seksuaaliterveyspalveluiden ammattilaisten keskuudessa avoimia kysymyksiä sisältävällä kyselyllä. Kysely toteutetaan sähköisesti loppuvuoden 2014 aikana.

Tutkimuksen taso

☐ Väitöskirja ☐ Lisensiaattitutkimus ☒ Pro gradu ☐ Ammatillinen opinnäytetyö

☐ Muu, mikä

Tutkimuksen kohde avopalveluissa

☒ Lasten ja nuorten terveyspalvelut
☐ Vastaanottotoiminta
☐ Mielenterveys- ja päihdepalvelut
☐ Suun terveydenhuolto
☐ Kotihoito
☐ Aikuisten sosiaalipalvelut
☐ Lapsiperheiden sosiaalipalvelut
☐ Muu
☐ Yhteistyö Tampereen Praksis-hankkeen kanssa

Pääasiallinen tutkimustapa / menetelmä

☒ Kysely
☐ Haastattelu
☐ Havainnointi
☐ Asiakirja/tilastoanalyysi
☐ Muu, mikä:

Alaikäisen lapsen haastattelu tai havainnointi edellyttää aina huoltajan kirjallista lupaa.

Aineiston suunnitelu keruuaika

Alkaa	Päättyy	Tutkimuksen arvioitu valmistumisaika
15.12.2014	31.12.2014	Toukokuu 2014

4 YHTEYSHENKILÖ(T) AVOPALVELUISSA

Tutkimusluvan myöntämisen edellytyksenä on, että hakija on ollut yhteydessä siihen avopalvelujen yksikköön, johon tutkimus kohdistuu. Asianomaisen yksikön yhteyshenkilö/t nimetään alla olevaan kohtaan.	
Nimi ja yksikkö Tuire Sannisto, lasten ja nuorten terveyspalvelut	**Puhelin ja sähköposti** 050 468 9166, tuire.sannisto@tampere.fi
Nimi ja yksikkö	**Puhelin ja sähköposti**
Nimi ja yksikkö	**Puhelin ja sähköposti**

5 TUTKIMUKSEN KOHDE

a) Asiakirjatiedot mistä dokumenteista, tilastoista, rekistereistä haetaan tietoa

- mitä tietoa edellä mainituista asiakirjoista tutkitaan

b) Muu tutkimuksessa käytettävä aineisto (esim. haastattelu, kysely)

Avokysymyksiä sisältävä kysely, toteutetaan sähköisesti (kyselylomake ja saatekirje liitteenä)

- tutkimuslupahakemukseen liitetään malli tutkittavalle lähetettävästä kirjeestä sekä suostumusasiakirjasta.

c) Arvio osallistuvan henkilökunnan työajan käytöstä

Kyselyyn vastaaminen vie noin 20 minuuttia

d) Arvio miten tutkimus hyödyntää kaupungin palvelujen kehittämistä

Tutkimuksen tuottaman tiedon avulla voidaan edelleen kehittää ehkäisyneuvonnan hedelmällisyysneuvontaan liittyviä käytäntöjä ja palveluita STM:n seks. ja lisääntymisterv. edistämisen toimintaohjelman mukaisesti.

6 TUTKIJAN TAI TUTKIJOIDEN SITOUMUS JA ALLEKIRJOITUKSET

Sitoudun siihen, etten käytä saamiani tietoja tutkittavan tai hänen läheisensä vahingoksi tai halventamiseksi taikka sellaisten etujen loukkaamiseksi, joiden suojaksi on säädetty salassapitovelvollisuus, enkä luovuta saamiani henkilötietoja sivullisille. Sitoudun tutkijan eettisiin periaatteisiin.

21.11.2014

Päiväys **Allekirjoitus ja nimen selvennys** Minna Kaattari

Päiväys **Allekirjoitus ja nimen selvennys**

Hakemuksen liitteet

- [x] Tutkimussuunnitelma
- [x] Kysely/haastattelu yms. lomake
- [ ] Aineistonkeruulomake
- [x] Muu aineiston keruuseen liittyvä materiaali (esim. yhteydenottokirje ja suostumusasiakirja alaikäisen huoltajalle)

- [x] Tutkimukseni voidaan julkaista Tampereen kaupungin julkaisusarjassa tai Internet-sivulla.

Tallenna | Tulosta | Tyhjennä

7 TUTKIMUSLUPAHAKEMUS LÄHETETÄÄN OSOITTEELLA:

TAMPEREEN KAUPUNKI

Aikuisten sosiaalipalvelut
Sosiaalipalvelupäällikkö Tuula Haapio
Hatanpäänkatu 3 F, 33900 Tampere

Lapsiperheiden sosiaalipalvelut
Vs. sosiaalipalvelupäällikkö Hanna Harju-Virtanen
Hatanpäänkatu 3 F, 33900 Tampere

Lasten ja nuorten terveyspalvelut
Ylilääkäri Tuire Sannisto
Hatanpäänkatu 3 F, 33900 Tampere

Vastaanottotoiminta
Ylilääkäri Kati Myllymäki
Hatanpäänkatu 3 F, 33900 Tampere

Kotihoito
Kotihoidonpäällikkö Erja Pennanen
Hatanpäänkatu 3 F, 33900 Tampere

Suun terveydenhuolto
Ylihammaslääkäri Eeva Torppa-Saarinen
PL 437, 33101 Tampere

Mielenterveys- ja päihdepalvelut
Ylilääkäri Päivi Kiviniemi
Hallituskatu 8, 33200 Tampere

8 PÄÄTÖS

☒ **Tutkimuslupa myönnetään seuraavin ehdoin:**

1. Tutkija sitoutuu tietojen käsittelyssä ja suojaamisessa noudattamaan henkilötietolain määräyksiä.
2. Tutkimuksessa mahdollisesti syntyvät yksittäisten henkilöiden tietoja koskevat tutkimusrekisterit hävitetään tai arkistoidaan henkilötietolaissa edellytetyllä tavalla.
3. Mahdollisesti tarvittavassa suostumusasiakirjassa tulee ilmetä ao. henkilön lupa käyttää häntä koskevia tietoja, tutkimukseen osallistumisen vapaaehtoisuus ja henkilöiden mahdollisuus keskeyttää osallistuminen tutkimukseen heti niin halutessaan.
4. Tutkimuslupa ei oikeuta hakemaan tietoja Hyvinvointipalvelujen tietojärjestelmistä.
5. Tutkimuksen valmistuttua tutkimusraportti toimitetaan asianomaiselle yhteyshenkilölle.
6. Jos tutkimus keskeytyy, siitä ilmoitetaan yhteyshenkilölle ja tutkimusluvan myöntäjälle.
7. Alaikäisten lasten haastatteluun pyydetään aina huoltajien kirjallinen lupa.
8. Lupa voidaan peruuttaa, jos lupapäätöksen ehtoja rikotaan, jolloin luvansaajan on palautettava tutkimusta varten saamansa tiedot.
9. Lupa on voimassa hakemuksessa määritellyn ajan.

Muu:

☐ **Tutkimuslupaa ei myönnetä**

Perustelut liitteenä

Päättäjä

Tuotantoyksikön päällikkö

Päiväys
3 / 12 / 14
___/___20___

Tuire Sannisto
LT, ylilääkäri
Tampereen kaupunki / Avopalvelut
Lasten ja nuorten terveyspalvelut
PL 98, 33201 Tampere
tuire.sannisto@tampere.fi
puh. 050 468 9166, cid 76268

10. PÄÄTÖKSEN JAKELU

1. **Hakija** **Päiväys** 3/12/2014 ☐ **Lähetetty** MKR
2. **Yhteyshenkilö**

TURKU HYVINVOINTITOIMIALA

Tutkimuslupa
Anomus/Päätös

Tutkimustyyppi, johon lupaa haetaan

- ☐ Lääketutkimus
- ☐ Muu ulkopuoliselta rahoitusta saava tutkimus
- ☐ Muu hanke
- ☐ EVO-tutkimus
- ☒ Opinnäytetyö

Fertility counselling in Finnish primary health care
Tutkimuksen nimi

Minna Kaattari
Hakijan/vastaavan tutkijan nimi

071181-1227
Henkilötunnus

Henkilönumero

Opiskelija
Nimike

Tampereen yliopisto, Terveystieteiden yksikkö
Tulosalue/tulosyksikkö

Eerikinkatu 9 A 18, 00100 Helsinki
Osoite

minna.kaattari@gmail.com
Sähköpostiosoite

040 540 6745
Puhelinnumero

Oman yksikön henkilöstön käyttötarve

Tarvittava ulkopuolinen työvoima

Sisäisten palvelujen tarve

Tutkimuksen laajuus
(potilaiden lukumäärä tms.)
ei potilaita, vain ehkäisyneuvolan henkilökunta

Tutkimuksen aikataulu
02 / 01 20 15 – 31 / 01 20 15

Arvio tutkimuksesta aiheutuvista kustannuksista

- palkat: 0 €/ei kustannuksia ko. yksikölle €
- henkilöstösivukulut: 0 €/ei kustannuksia ko. yksikölle €
- asiakasmaksut: 0 €/ei kustannuksia ko. yksikölle €
- muut kulut: 0 €/ei kustannuksia ko. yksikölle €

Tutkimukseen ulkopuoliselta rahoittajalta saatavat korvaukset (maksajat, eurot)
0 €/ei korvauksia

Käyntiosoite
Yliopistonkatu 30
20100 TURKU

Postiosoite
PL 670
20101 TURKU

Faksi
02 2662 899

Puhelin
02 2662 211 (vaihde)

Sähköposti
etunimi.sukunimi@turku.fi
hyvinvointitoimiala@turku.fi
www.turku.fi

35.381s Painatuspalvelut

Suunnitelma ulkopuolelta saatavien korvausten edelleen ohjaamisesta, esim.
– henkilöille maksettaviin palkkioihin sivukuluineen — 0 €/ei kustannuksia/korvauksia ko. yksiköllle €

– hyvinvointitoimialan tulotileille (asiakasmaksuihin, sisäisiin palveluihin ym.) — 0 €/ei kustannuksia/korvauksia ko. yksiköllle €

– tulosyksikölle siirrettäväksi sponsorirahaksi — 0 €/ei kustannuksia/korvauksia ko. yksiköllle €

Liitteenä

– eettisen toimikunnan lausunto tarvitaan ☐ ei tarvita ☒ liitteenä ☐
– tutkimussuunnitelma (tiivistelmä) ☒
– kopio lääkelaitokselle tehdystä ilmoituksesta ☐
– rekisteröinti tiedekuntaan tehty ☐ vireillä ☐ ei tarvita ☒

Haen lupaa tutkimuksen tekemiseen.
Sitoudun samalla vastaamaan tietojen käytöstä sekä siitä, että tutkimusryhmäni noudattaa tietosuojaa koskevia määräyksiä.

Puerto Rico, Espanja 18 / 12 20 14

Hakijan allekirjoitus

Tulosyksikön johtajan lausunto

tutkimus oh, tuottaa tietoa hh:n osaamisesta

Puollan ☒ en puolla ☐

22 / 12 20 14

Allekirjoitus

Tulosaluejohtajan päätös

Myönnän anotun mukaisesti ☒ en myönnä ☐

390008

Päättäjäkoodi

15 §

TURKU 22 / 12 20 14

Allekirjoitus

JAKELU hakija
tulosyksikön johtaja
tulosaluejohtaja
kehittämisen yksikkö

Annex 6 Results in tables

FAMILIARITY			
Initial idioms and expressions	Categories	Results	Themes
- Part of the education - Part of work description - An essential part of contraceptive counselling (CC) - From training - From literature	All respondents were familiar with the topic of fertility counselling and issues related to it	The professionals are familiar with the topic of FC and consider it as a part of their work	Familiarity with fertility counselling
- Given daily for the clients - One of the most important topics - CC contraceptive counselling cannot be given without this field - Health behaviours in general - Pregnancy wishes (e.g. in the context of the pills, removal of IUD) - Termination of pregnancy	All respondents have given fertility counselling as a part of their job	FC is considered as an essential part of sexual health services	

IMPORTANCE			
Initial idioms and expressions	Categories	Results	Themes
- One of the most important topics - Not possible to give CC if not familiar with fertility issues and the contraceptives' impact on fertility	When asked about the importance of the concept for their work, all respondents considered it important, very important or even inevitable -> All respondents consider FC as an important for their work	FC is considered important part of sexual health services and the work of professionals	Importance of fertility counselling
- The field of sexual and reproductive health - An essential part of the job - Everyone benefits - Prevention and health promotion - Infertility - Pregnancy - Clients' future, fears, worries important - Risk factors: weight, smoking, STIs, age - Chlamydia infections - Terminations - Women of 35–45 of age - Woman as a whole, female fertility	Everyone would benefit from FC vs. women would benefit from FC	The target of FC: Women as clients of contraceptive clinics vs. The population as a whole	

THE CIRCUMSTANCES			
Initial idioms and expressions	Categories	Results	Themes
- Lack of time/hurry/the length of the appointment (most common) - Scarce resources and lack of staff (partly re: to previous) - Accessibility of the services: do the clients get an appointment in time/early enough? - The skills of the staff? - The structure of the services makes it difficult to follow progress of the clients	Most of the respondents felt that there are some challenges or obstacles in their work for giving FC	Working conditions pose some challenges for implementing FC, most important of them being time and its restrictions for giving fertility counselling	Circumstances for giving fertility counselling
- Collaboration within and outside the unit - Talked about among the colleagues - Clients: interested, receptive, positive towards FC - CC as a field enabling/supporting, easy to bring up issues related to FC - Their own education and the job description - Training opportunities	All but one respondents mentioned at least one benefit or enabling factor	Working conditions provide several positive factors for implementing FC	
- Interested about FC - Receptive - Positive towards it, though at times not listening (esp. if some improvement needed) - Worried about the impact of the pills on fertility - Not always familiar with age-related fertility issues	- The clients mostly receptive and interested about the topic - Misbeliefs e.g. on the pills - Lacking knowledge on age and its impact	Most of the respondents highlight the importance of clients and clients groups and their attitude towards fertility counselling in giving the counselling	

MEETING THE NEEDS			
Initial idioms and expressions	Categories	Results	Themes
- Age and its impact on fertility as an issue that should be reminded especially after the person has turned 30 - Given as a part of guidance for planning subsequent pregnancies - Sometimes, should be given more in general because the misbeliefs the youth have on the pills	Nearly everyone have given age-related FC (answered yes to the direct question) but in general the age-related matters of FC are very rarely mentioned - Age-related FC is understood as a part of the services but may not be fully implemented as a part of the practices/not a priority - Considering the easiness of bringing up the topics of FC, it should be relatively easy to discuss age as well	- The need for age-related FC seems unmet - Age-related FC should be further highlighted in the work of the professionals and also in training - The professionals may require more additional training/education on the matter	Meeting the needs – age- and Chlamydia-related fertility counselling
- Remarks like 'always', 'of course', 'naturally' - Hormonal contraception considered as a protective factor - Sometimes not mentioned if the first infection of the client (do not want to scare clients)	Everyone has given FC in the context of Chlamydia infections and there are several other references to it throughout the data Giving FC in the context of Chlamydia infections seems like a norm and part of the routine	The need of giving FC in the context of Chlamydia diagnoses seems to be largely met	

AVAILABILITY			
Initial idioms and expressions	Categories	Results	Themes
- Belongs together with sexual and contraceptive education - Significant for well-being - Own clinic for those planning for pregnancy, focused on counselling - Should be discussed at every appointment - The services in question should be further developed and organised - Clients are open to it, aware and open for discussion - One of the most important tasks of public health care - Important because infertility is difficult matter/personal worries - Economically cheaper to the society/in long-term, a cost-effective option - Important because often clients have wrong impressions e.g. that prolonged use of the pills increases infertility - Preventing unwanted pregnancies and increases the possibility of family planning - Important because not everyone can afford private health care	- The professionals see FC as an important and essential part of publicly funded sexual health services - Further development and reorganisation of the services are hoped for All the respondents considered providing FC as important for public sexual health care services	In future FC should be continued to be considered as an vital part of public sexual health services and as a such should be further developed and reorganised	Availability of fertility counselling

- Primary health care: • As a part of basic services • Health check-ups • Youth clinics • When suitable, at doctor's and nurse's appointments - Sexual health services: • Contraceptive clinics • Maternity clinics • Other family planning services • In a case of termination of pregnancy • When suspecting, testing or diagnosing STIs • During gynaecology appointment - Schools and universities: • Health education at schools • School and student health care • Health check-ups	The professionals view that FC should be a part of comprehensive sexual health services targeted for everyone and at every level of health services	FC provided in primary and sexual health care should be scaled up starting from sexual education provided at schools and the knowledge level should be maintained through systematic provision of counselling	

Annex 7 Kyselylomake

KYSELYLOMAKE

Ikä:
Sukupuoli:
Ammattinimike, organisaatio, koulutus:
Vuodet nykyisessä tehtävässä:

> Hedelmällisyysneuvonnalla tarkoitetaan tässä kyselyssä hedelmällisyystietouden lisäämistä. Hedelmällisyystietous on tietoa siitä, miten raskaus alkaa, milloin raskaus on mahdollinen, mitkä tekijät vaikuttavat hedelmällisyyteen, ja mitkä tekijät voivat heikentää hedelmällisyyttä. Hedelmällisyysneuvonnalla voidaan vaikuttaa ennaltaehkäisevästi hedelmällisyyttä uhkaaviin tekijöihin kuten ali- ja ylipainoon, tupakointiin sekä iän ja klamydiainfektioiden vaikutuksiin hedelmällisyyden kannalta. Hedelmällisyysneuvonnalla lisätään nuorten ja aikuisten hedelmällisyystietoutta, jotta he voivat tehdä tietoisia ratkaisuja lisääntymisen suhteen.

1. Yllä on kuvattu hedelmällisyysneuvonnan termi. Onko termi sinulle ennestään tuttu? Mistä yhteydestä?
2. Oletko antanut hedelmällisyysneuvontaa osana työtäsi? (Jos et ole, voit siirtyä kohtaan 6)
3. Jos olet, niin minkälaista tai missä yhteydessä? Miten asiakkaat ovat siihen suhtautuneet?
4. Oletko antanut ikään liittyvää hedelmällisyysneuvontaa?
5. Entä klamydiadiagnoosin yhteydessä?
6. Koetko hedelmällisyysneuvonnan tärkeäksi työsi kannalta? Miksi/miksi et?
7. Koetko, että asiakkaasi hyötyisivät hedelmällisyysneuvonnasta? Jos, niin tuleeko mieleesi erityisesti jokin asiakasryhmä/ryhmiä?
8. Oletko keskustellut hedelmällisyysneuvonnasta yksikössäsi tai kollegojen kesken? Kerro esimerkki.
9. Oletko saanut aiheeseen liittyvää koulutusta tai lisäkoulutusta? Missä ja minkälaista?
10. Mistä saat tai haet hedelmällisyysneuvontaan liittyvää lisätietoa?
11. Onko työssäsi tekijöitä, jotka voivat asettaa haasteita tai esteitä sille, että hedelmällisyysneuvontaa voitaisiin antaa osana sitä? Mitä nämä haasteet tai esteet ovat, ja miten ne mielestäsi rajoittavat hedelmällisyysneuvonnan antamista?
12. Koetko, että työssäsi on sellaisia tekijöitä, jotka tukevat tai mahdollistavat hedelmällisyysneuvonnan antamisen? Kerro esimerkki.
13. Kuinka tärkeää on mielestäsi tarjota hedelmällisyysneuvontaa osana julkisia seksuaaliterveyspalveluita? Miksi/miksi ei?
14. Jos koet hedelmällisyysneuvonnan tärkeäksi, niin missä tilanteessa tai tilanteissa tai minkä palveluiden yhteydessä sitä tulisi mielestäsi tarjota osana julkisia seksuaaliterveyspalveluita?
15. Haluatko tuoda tutkimuksen tiedoksi vielä jonkin aiheeseen liittyvän näkökulman, jota ei ole kysytty kyselyssä?

Annex 8 Saatekirje

Tiedote tutkimukseen osallistujalle

Pro gradu -tutkielmani tavoitteena on selvittää perusterveydenhuollon hedelmällisyysneuvontaan liittyviä käytäntöjä sekä perusterveydenhuollossa työskentelevien seksuaaliterveyden ammattilaisten näkemyksiä hedelmällisyysneuvontaan. Aihe on työstetty yhdessä yhdessä THL:n seksuaali- ja lisääntymisterveyden yksikön kanssa (ohjaajana LT Teija Kulmala). Tutkielma on osa Tampereen yliopistossa suorittamaani englanninkielistä terveystieteiden maisterintutkintoa. Tutkielman raportointia varten kyselylomake ja vastaukset käännetään englanniksi. Alkuperäinen suomenkielinen kyselylomake liitetään osaksi tutkielmaa. Aineistoa kerätään Helsingissä ja Tampereella sekä mahdollisesti myös Turussa ja/tai Espoossa.

Tutkimuksen aineisto kerätään avokysymyksiä sisältävällä lomakkeella sähköisesti. Vastaaminen kestää noin 20 minuuttia. Tutkimuksen tulokset raportoidaan pro gradu -tutkielmassa anonyymisti. Vastauksia voidaan tarvittaessa käyttää raportissa englanniksi käännettyinä sitaatteina ja tutkimuksen tekijä varmistaa, että vastaajan henkilöllisyyttä ei voi päätellä käytetystä sitaatista. Henkilöllisyytesi, vastauksesi ja kaikki tutkimuksen aikana esiin tulevat asiat ovat luottamuksellisia eikä niitä luovuteta ulkopuolisille. Tutkimukseen osallistuminen on vapaaehtoista ja osallistumisen voi halutessaan keskeyttää missä tahansa vaiheessa. Olisi erittäin toivottavaa, että vastaisit mahdollisimman laajasti esimerkeillä havainnollistaen viimeistään 7.1.2015 mennessä.

Hedelmällisyysneuvonta aiheena on nostettu esiin STM:n uudessa seksuaaliterveyden edistämisen toimintaohjelmassa mutta sitä on tutkittu vielä kovin vähän. Aikaisemmissa tutkimuksissa on kartoitettu lähinnä seksuaaliterveyspalveluiden käyttäjien näkemyksia aiheesta mutta seksuaaliterveyden ammattilaisten näkemyksiä asiasta ei ole aiemmin tutkittu. Täten on erittäin tärkeää, että kaikki tutkimukseen osallistuvat vastaisivat kyselyyn mahdollisimman laajasti ja perusteellisesti. Kyselyyn osallistuneet yksiköt saavat tutkimustulokset käyttöönsä ja tuloksia tullaan toivottavasti esittelemään laajemminkin seksuaaliterveyden ammattilaisten parissa.

Jos sinulle jäi kysyttävää, haluat keskustella tutkimuksesta enemmän tai mieluummin keskustelet aiheesta kasvotusten, otathan yhteyttä.

Kiitos osallistumisestasi tutkimukseen!

Ystävällisin terveisin,
Minna Kaattari
040 540 6745, minna.kaattari@gmail.com
Terveystieteiden yksikkö, Tampereen yliopisto